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Homelessness in Wisconsin: Current Situation and Future Prospects

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A Coordinated Approach to Housing the Homeless Mentally Ill

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Homelessness in Wisconsin from 1838 to 1870

In the initial period of European settlement in Wisconsin makeshift housing was commonplace. Indeed the "Badger State" term derives from a description of one type of temporary housing. During the early settlement phase there was no public responsibility for the housing or sustenance of the poor or the pauper. The able-bodied person who was 'willing to work' was presumed to be able to support themselves and their family in normal circumstances. Personal disasters might elicit aid from neighbors and friends, or as was the case in general economic downturns, people simply left and moved to more promising areas.

The first Legislative act for the provision of relief and support for the poor in Wisconsin was passed in 1838. This Territorial Act placed responsibility for relief with the county board commisssioners. As towns and counties were organized, provision for the destitute was seen as an essential element in local government. Almost without exception, responsibility for relief was adopted within the first year (indeed many towns and counties had methods of relief prior to formal formation) (Carver, 1917). In 1849 the new State of Wisconsin legislated for both county and town systems of relief. The mixed pattern of relief administration has continued almost to the present time.

Early relief provision in Wisconsin was established locally following traditional attitudes and policies derived from the English Poor Law system of relief. In this system a person was attached to a specific place [a Parish] and it was the responsibility of the parish to regulate the welfare of its indigent population (Ribton-Turner, 1887). The eastern colonies and later the frontier states inherited the "local" pattern of relief and punishment for the indigent and vagrant classes (Riis, 1890). Almshouses (and outdoor relief) were provided for the deserving indigent, local poorhouses and workhouses were for the less deserving and the vagrant. In Wisconsin the civil units of towns and counties substituted for the English parishes.

Homelessness and vagrancy in Wisconsin derived from the same sources as in the eastern colonies and England: poverty, disability, age and choice. Public and private responses also followed the eastern and English patterns, with private charities opening almshouses and soup kitchens and some public relief. The dynamic economy and westward expansion provided opportunities to the poor of the eastern cities which prevented the build up of large destitute urban populations until the later part of the 1800's. Wisconsin and other frontier states absorbed, at least for a while, labor that was surplus on the eastern coast (Riis, 1890). This workforce was important in the early labor intensive period of settlement. (The westward transfer of labor also included destitute and orphaned children sent as indentured laborers to Wisconsin farms.)

The treatment of people who could not support themselves varied radically depending on public and administrative attitudes toward the cause(s) of an individual's dependence. In the initial period of Wisconsin settlement a considerable degree of social scanction was associated with receiving public relief. For example, town boards were required to report each year, the name and amount of support received by each person or family. The aim of this requirement was to keep the number of applications as low as possible (Carver, 1917). Some town boards took the requirement one step further by requiring applicants to appear at a public hearing in front of the whole town board and to present reasons why they should be granted aid. When aid was granted, it was frequently linked to required work (usually on the town roads). The amount of aid was usually left to the discretion of the town officers.

A number of counties also administered relief in the early period of statehood. The usual case was that the town chairmen would decide (in County Board meeting) that they wished the county to administer the relief program. In practice there was considerable shifting of responsibility and hence confusion as townships sought (usually for financial reasons) to have the county take over the costs of relief yet to retain control at the township level.

The situation of the indigent and dependent population in Wisconsin was not significantly different than that in many states in the 1860's. In addition to the state prison (established in 1850), there were several institutions established for segments of the dependent population:

Population	Established
Blind	1850
Deaf	1854
Insane	1854
Delinquent Boys	1857

The indigent who did not fall into these categories (and some who did) were usually confined to local poorhouses. While the state institutions were generally overcrowded and under-staffed, appaling conditions existed in the local poorhouses. The county and town poorhouses were designed to discourage use. Located in isolated areas, their inhabitants faced poor food and lack of beds, sanitation and even fresh water. Confined within these poorhouses were indigent men, women, and children, and persons with various disabilities.

Homelessness in Wisconsin from 1870 to 1930

In the aftermath of the dislocations of the Civil War, Wisconsin like many other states undertook several studies aimed at reorganization and reform of its public welfare efforts. In 1871 the newly established Board of Charities and Reform began systematic investigations into the conditions in all state institutions as well as town and county facilities. The conditions discovered were described as "filthy", "disgusting", "offensive", with "beds full of vermin", "walls clotted with blood", "urine running over the floor", and "a disgrace to the state".

The reform movement led to the establishment of several specialized programs to serve particular subpopulations within the general welfare program. There appear to have been three threads running through this reform movement. First there were efforts to reform the conditions prevailing in the poorhouses themselves. Unfortunately, although uniform standards were developed for poorhouses, the Board of Charities and Reform was only able to recomend changes. Some counties and towns simply ignored the recomendations. Second, there was a often voiced concern that individuals with disabilities be seperated from the "pauper class". These concerns stemed from the perception that people with disabilities were deserving of help. Indigent yet deserving individuals were to be well provided for, while the pauper was to be erradicated. Finally, there were pressures to expand the classes of individuals who could call on the state for support as a right. In effect, the reform movement of the 1870's sought to improve the lot of those people identified as 'deserving' and to extend the definition of deserving.

In 1878 and 1881 the "Wisconsin System" of county asylum care for the chronically mentally ill was introduced in an effort to relieve the overcrowding and mixing of people with mental illness, mental retardation, and the "chronic insane" at the state mental hospital, poorhouses, county jails and insane asylums. In the 1880's 18 county asylums were constructed, and by 1900 a further 9 had been added to the county asylum system. The mental health system (in the 1880's and 1890's) thus consisted of;

Institution	Population Served
State Hospitals	Acute or curable mentally ill.
County Asylums	Chronically mentally ill.

Many mentally retarded persons who were technically excluded from these facilities were classified as "insane" and committed to county asylums. However, as the cost increased, the state (in 1894) responded by forcing counties to strictly enforce eligibility criteria (thus reducing state reimbursement). The net result was a surge of mentally retarded people who were admitted to poorhouses in the next three years (Rugg, 1983). This example of progressive reform improving conditions for some, excluding some, and the service system adjusting to the change has been repeated several times. In general, the aim of separating the deserving from the undeserving has been conditioned by the cost of serving all those defined as deserving.

As previously noted, as the state began to serve segments of the population previously unserved or underserved there was increasing advocacy for expansion of those who would be eligible for services; mentally retarded children, disabled aged, and persons (particularly children) with multiple disabilities. While eligibility was expanded, the division of the indigent population into deserving and undeserving clearly placed vagrants in the undeserving class; it would be several decades before the alcoholic or the day laborer would be seen as deserving of some assistance (Allen, 1903).

The expansion of services and eligibility in the period from the 1890's to 1930 was heavily influenced by the current views and practices of social service professions. For example, the eugenics movement with its view that 'genetic defectives' were likely to become paupers, criminals and insane, directly influenced the type of care directed toward those groups. Wisconsin, along with many other states, introduced sterilization to prevent the transmission of the genes of persons who had undesirable traits. (see Komisar, 1977 for a history of the interplay between reform movements, welfare programs, and increasing bureaucratization).

While the State of Wisconsin moved into a more active position with regard to the dependent population, the growing urban areas presented a new phenomena for Wisconsin-- the emergence of urban concentrations of poverty. In the thirty years prior to the turn of the century slums emerged in the larger towns and cities of Wisconsin. By the 1890 Census it is possible tc identify definite areas of cities were concentrations of poverty and low quality housing coincide. The Census primarily counted the domiciled population, but as the numbers of the poor increased, concentrations of homeless and near homeless individuals and families could be observec living in the open, in shanty towns or boarding houses (Booth, 1890 gives the U.K. comparison).

Relief agencies focused on these areas, anc their activities drew still more people who were homeless and discouraged competing activities. Here we see the outcome of public policies which forced people who were homeless to leave specific locations, the establishment of relief agencies in areas of concentration of the poor, and the focus on relief of current crisis needs (food, shelter), rather than long term solutions (Gault, 1914).

Homelessness during the Depression, War, and Recovery

The Great Depression led to widespread poverty in Wisconsin which exposed the inherent structural problems of administering the Wisconsin system of relief. The state became involved through the provision of funds for public relief employment. This was the first time that local units were directly aided by the state for the provision of public assistance. It is also notable that the state treated local units differently according to the amount of need and the local unit's ability to meet that need. Federal funds for relief ended in 1936 and was quickly followed by a reorganization of relief activities In general, counties became the focus of relief (42 counties), while local units remained in control in 14 counties and in 15 counites local units formed groups to administer relief.

One major effect of the Great Depression was the Citizen's Committee or Public Welfare (1937). The Committee made many recomendations such as the transfer of relief activities to the counties, state-funded support for transients, and a work based relief program for the unemployed. The recomendations of the committee had little effect and the fragmented administrative structure continued.

The upturn in the economy during the Second World War reduced the destitution due to unemployment. The burden of relief was not entirely eliminated due to the number of people who were unable to work or were transient (Brantner, 1959). The new Social Security system did not really grow substantially until after the end of the war, so that most relief depended on local or state resources.

In the post-war period, pressures on the relief structure stemed primarily from the growth in destitution due to unemployment. In the 1950's the transient was still vulnerable to arrest and vagrancy charges. The person with mental illness was also vulnerable to institutionalization which was seen as the most appropriate care for many types of mental illness (Bogue, 1963). This is also the period of the introduction of major efforts directed toward the treatment of alcohol abuse as a disease rather than a criminal offense. The change in attitude toward the abusive use of alcohol led to confinement in treatment facilities rather than jails (Fry and Miller, 1975). Thus several segments of the traditional homeless population were removed from the destitute group by being confined or moved on to another jurisdiction.

Homelessness in Wisconsin : The Last Twenty Years

Nationally in the 1960's the effects of the post World War II housing construction boom and flight from the central city were becoming apparent in many cities. Deteriorating housing and inner city unrest contributed to a major effort to renew the central cities. Widespread demolition of substandard buildings eliminated much of the housing which would normally have provided shelter to those persons in extreme poverty (Miller, 1981).

By the mid 1960's the relative prosperity of the period had contributed to a decline in the number of people who were homeless and consequently the notion of urban renewal of skid row was seen as a practical method of dealing with the homelessness problem (Bogue, 1963). It was thought that by removing the cubical and SRO hotels, people who were homeless would move to better accomodations (which, in theory, had been left vacant by households leaving the city). However, at the same time as skid row was being "renewed" other housing was being demolished or upgraded. Federal and city building standards required removal or renovation of substandard housing. In the 1960's these standards became progressively more stringent. The net result was a drastic reduction in availability of affordable housing for those in extreme poverty.

The upgrading of housing conditions and building codes were not limited to the large urban centers. Rural communities also enacted tighter building codes, often in response to state and federal aid programs. Rural areas in Wisconsin were faced with increasing expectations from their residents and increasing requirements from state and federally mandated programs. Although many rural areas lacked the financial-ability to pay for these programs, building and zoning requirements were 'cost free' and sometimes brought additional funds.

The growth in the number of people who were homeless that occurred in the 1970's is not surprising considering the policies being applied during the period (Hombs and Snyder, 1982, Hopper, 1985). The urban renewal policy removed much of the lower end of the housing market in central cities (Downs, 1983, Kasinitz, 1984). The very poor resident could not afford or function in the remaining housing without a significant increase in social and economic supports. While economic and social support programs did increase, they were not sufficent to ensure the housing of the poor (Miller, 1981, Auletta, 1983, Norton, 1983).

Housing and income policies were not the only policies which contributed to the rise in the number of people who were homeless in the 1970's (Garrett and Bahr, 1976). The deinstitutionalization the mentally ill population which began in the mid-1960's reached its peak in the early 1970's. Some of the deinstitutionalized population became homeless and swelled the number of people on the streets (Braun et. al., 1981, Friedman, 1983, Hope and Young, 1984). These individuals also fundamentally altered the characteristices of the homeless population (Bachrach, 1984).

For most of U.S. history the homeless population had had two major components: the economically disabled (the working poor and destitute) and the physically disabled (including the alcoholic) (See Bahr, 1973, Bahr et. al., 1976, and Cohen and Sokolovsky, 1983, for modern sociological treatments of this segment of the population). These two components fluctuated in size with public attitudes and the state of the economy (Bassuk, 1984). The mentally ill population thus added another major component to the homeless population, a component that service agencies were often completely inexperienced in dealing with in a community setting (Chmiel et. al., 1979, Smith and Hanham, 1982, Dear and Taylor, 1982, Burnett and Moon, 1983). Initially the person with chronic mental illness who become homeless had been deinstitutionalized and tended to be middle-aged (Reich and Siegel, 1978). More recently, younger persons who have been denied admission have been added to the population (Segal et. al., 1977, Hopper et. al., 1982, Goldman, Adams and Taube, 1983, Lamb, 1984). Thus, the component of the homeless population that is mentally ill has within it considerable variations in past experience and contact with the mental health system (Williams, 1977, Bachrach, 1984, APA, 1984,, Baxter and Hopper, 1984).

The late 1970's and early 1980's have seen the addition of more and more families to the homeless population (Cuomo, 1983, Stern, 1984).

The rapid rise in rental rates, coupled with condominium conversions and the virtual elimination of public housing construction has squeezed many families out of the housing market (Dolbeare, 1983, Downs, 1983). These families have placed additional burdens on emergency housing services. Like people who are mentally ill, families have special needs that traditional shelter providers have not been accustomed to dealing with in the past. Another group which experience difficulties in the housing market is ex-offenders. These persons are disadvantaged in the labor market and thus tend to have low incomes while also experiencing discrimination in the housing market. Providing housing services to these individuals requires both specialized service delivery models and personnel (Greenwood, 1975). This mix of needs within the homeless population has emerged as one of the major difficulties in delivering services (Cuomo, 1983, Stern, 1984).

By the early 1980's, the size of the homeless population of the U.S. was variously estimated to be under 1 million (HUD) to as high as 2 million (Hopper et al., 1982, Leepson, 1982). While the absolute size of the population is a subject of considerable debate, there is a consensus that people who are homeless have significant problems. Approximately 40% of the homeless population are heavy users or abusers of alcohol, 30% suffer from chronic mental illness, and virtually 100% are destitute (Freeman et.al., 1979, Depp and Ackiss, 1983, Cuomo, 1983, Stern, 1984). The U.S. Congress has had several hearings as the homeless problem has emerged. These provide the best sources for many of the individual city studies (U.S. House of Representatives, 1983, U.S. House of Representatives, 1984).

Wisconsin has not avoided the increase in the numbers of people who are homeless. While experiencing lower levels of poverty than the nation as a whole, Wisconsin nonetheless has significant numbers of persons in poverty (Kanskie, 1985). The same trends that are involved in the national increase in homelessness are also at work in Wisconsin (Salerno et. al., 1984, U.S. Conference of Mayors, 1984). Removal of low income housing, deinstitutionalization, and inadequate poverty support payments for the very poor have all been documented in Wisconsin (Salerno et. al., 1984, Rosnow et. al., 1985, Stapleton Concord, 1985). While some community support programs in Wisconsin are among the best in the nation, others are less well developed (Test and Stein, 1978). The studies of the homeless mentally ill population in Wisconsin indicate rather extensive contact with the mental health system, but also a significant level of disengagement (Rosnow et. al., 1985, Stapleton Concord, 1985, Rosnow et. al., 1986).

It is the overlapping problems of the constituents of the homeless population that present difficulties for service providers. For example, a person who is an abuser of alcohol, suffers from chronic mental illness, and has low job skills does not fit neatly into existing programs. Even the simple provision of shelter becomes a problem because rules which were normative in former years now present difficulties in the light of the changed needs of the homeless population (Segal and Baumohl, 1980).

The rapid growth in the number of people who are homeless further exacerbates the problem. Because there has been a lag in the allocation of funds to meet current needs, shelter and other service providers have been swamped with demands for shelter, food, job assistance, clothing, health care etc. (Parker, 1984). Many agencies are devoting the majority of their budgets to emergency care, making little provision for long term projects which could bring the homeless in off the streets permanentl (Stoner, 1984, U.S. Government Accounting Office, 1985).

Advocacy efforts on behalf of the homeless population were first directed toward documenting the problem (Priest, 1975, Rousseau, 1981). Initial studies aimed at getting accurate counts of the number of people on the street and providing sufficient shelter space. Later there were concerted efforts to use whatever legal or other resources were available to obtain and extend the rights of the homeless population (Pina, 1983, Fabricant and Epstein, 1984). The activation of public and private resources that has occured over the last five years has attempted to prevent deaths from exposure and move toward more long run solutions (Stoner, 1984). This course of events has not been universally supported as some have advocated no public involvement beyond stimulation of the economy to produce a general increase in income in the nation (Kondratas, 1985).

In many cities the immediate crisis has been met, at least in part, so that there is now the possibility of planning for more than emergency shelter (Leaf and Cohen, 1982, Rooney, 1980). While identifying the dimensions of homelessness remains an ongoing concern, many agencies and research studies are now turning to considerations of longer term solutions (Maz, 1983, Segal and Baumohl, 1980).

Growing recognition that people who are mentally ill may be particularly vulnerable to becoming homeless has led to a range of initiatives at local, state, and national levels. Just as there is no simple answer to how the problem developed there is no simple solution (Watson, 1986, Segal and Baumohl, 1980).

Preservation of existing low income housing is a critical aspect of the solution to homelessness (Watson, 1986, Lincoln, 1980, Cuomo, 1983). Recognition that SRO housing may have to be preserved and even constructed has led to several models (Connor, 1983, Marcus, 1981). More structured living arrangements that fall short of group homes have be sucessfully used in some localities (Otto and Orford, 1978). Highly structured living arrangements also seem to be sucessful for some persons (Wallich-Clifford, 1976).

These housing initiatives are only one part of the solution. Flexible approaches to treatment, and treatment that forms part of an integrated program are seem by most researchers as essential (Rhoads, 1981, APA, 1985, Erickson and Wilhelm, 1986).

Service delivery to vulnerable individuals as well as those already on the street is likely to involve rethinking of delivery models. There is a need to re-examine models, particularly with respect to the multiple problems that people who are homeless often have to deal with on a daily basis (APA, 1985, Erickson and Wilhelm, 1986).

While some agencies are already deeply involved in service delivery to people who are vulnerable or actually homeless, a wider involvement will probably be necessary for long term solutions to be sucessful (Stoner, 1984, U.S. Government Accounting Office, 1985). Agencies and groups not normally associated with people in great distress will likely be crucial because their actions can have profound effects. Housing authorities, community mental health agencies, public health centers, public and private welfare agencies and federal, state and local governments are some of the broad group of actors that have a role in solving the problem of homelessness (U.S. House of Representatives, 1983, U.S. House of Representatives, 1984). Any long run solution to the problem will thus necessarily rest on the development of consensus among service agencies and a range of public and private individuals and groups (Cuomo, 1983, Stern, 1984).

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Annotated Bibliography on Homelessness

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Annotated Bibliography on Homelessness

The following annotations cover both current and historical materials. The annotations are intended to provide a portal of access to the rather scattered literature on homelessness. The annotations are drawn from author abstracts as well as original annotations.

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Extensive review of the role of mental illness and deinstitutionalization in the increase in homelessness in the late 1970s and early 1980s. The authors note the failure of some CSP programs for some people who then are at increased risk of homelessness. This book remains controversial in that among the recommendations was a "reinstitutionalization" proposal, and the general "medical model" viewpoint expressed by some authors in the book. Some have pointed to the "sick" or "deviant" attitude that critics have seen as underlying the attitude toward the individual who is homeless.

Arce, A.A., Tadlock, M., Vergare, M.J., & Shapiro, S.H. (1983). A psychiatric profile of street people admitted to an emergency shelter. Hospital and Community Psychiatry, 34(9), 812-817.

This relatively early profile of the mental health of people who are homeless focuses on individuals who were identified as "crazy" by shelter providers, etc. The identification of relatively high rates of mental illness in this research is a result of the pre-screening by shelter workers. While some 85% of the subjects were judged to have some level of illness, it is notable that 15% of those prejudged by shelter workers as "crazy" were found to have no diagnosable mental illness.

Auletta, K. 1983. The Underclass. New York: Vintage Books, 348 pp.

The author seeks to find out who are the people behind the expanding crime, welfare, and drug statistics--and the rise in antisocial behavior that seems to be occuring most

American cities. The author notes that among students of poverty there is generally widespread agreement that a comparatively distinct black and white underclass does exist. Determining the size of America's underclass depends on one's definition of the term. If one includes all those officially classified as poor, according to the federal census, in 1980 there were 29.3 million Americans living at the poverty level: 19.7 million were white, 8.6 million were black, and 3.5 million were Hispanics. However, most students of poverty distinguish those who are temporarily poor from those more or less trapped in long-term poverty; it has been suggested that approximately 30% may be described as "acutely poor."

Bachrach, L.L. (1984). The homeless mentally ill and mental health services: An analytical review of the literature. Rockville, MD: National Institute of Mental Health.

Summarizes much of literature on mental illness and homelessness. Emphasis is on evaluations of "medical model" approaches. Much of the material reviewed here is also presented in APA (1984).

Bahr, H. (1973). Skid row: An introduction to disaffiliation. New York: Oxford University Press. [HV4505 .B34]

Explores skid row from the point of view of social pathology. Traces the chains of broken contacts (family, job, church, etc.) that lead to social vulnerability. This work represents the modern expression of the view of destitution as the result of social disorganization and breakdown.

Bahr, Howard M. and Garett, Gerald R. (1976) Women alone: the disaffiliation of urban women. Health, Lexington, MA, 207 p.

Data gathered from homeless women, collected from residents of the women's emergency shelter (New York City) were compared with reports of detachment from society among men as part of the Columbia Bowery Project in a study of urban disaffiliation. Disaffiliation is defined as detachment from society characterized by the absence or attenuation of the affiliative bonds that link settled persons to a network of interconnected social structures. It is reported that undersocialization, anomie, generational retreat, economic marginality, and occupational mobility are not predictors of disaffiliation for the women, but that a multivariate analysis reveals that age is the dominant predictor of affiliation. In comparison to the men, the shelter women were younger, poorer, more apt to come from broken homes, and to have been married. Both groups lacked contact with family and friends. Men misperceived, and therefore underreported, their drinking. It is concluded that the independent women are disaffiliated because of present circumstances which can be altered to facilitate reintegration.

Bassuk, E.L. (1984) The homelessness problem. Scientific American, 251(1):40-45, July.

During the winter of 1983/1984, more Americans were homeless than at any time since the Great Depression; the National Coalition for the Homeless put the 1983 figure at 2.5 million, an increase of half a million over the preceding year. There are, unfortunately, no reliable data on the homeless, the author notes, even though they have always been in great number in American cities. Anecdotal evidence has indicated that in the decades prior to the 1970s, most of the homeless were unattached, middle-aged, alcoholic men--inhabitants of Skid Row. Since about 1970, the population seems to have been growing progressively younger. And a more important change may be taking place: an increasing number--possibly even a large majority--of the homeless suffer from mental illness, ranging from schizophrenia to severe personality disorders. Shelters for the homeless find themselves with the impossible responsibility of replacing not only the almshouses of the past, but the large state mental institutions, as well.

Baxter, E., and Hopper, K. (1984). Troubled on the streets: The mentally disabled homeless poor. In J. Talbott (ed), The chronic mental patient: Five years later pp. 49-62. New York: Grune and Stratton.

While the emphasis is on NYC, this paper presents the core of the advocacy position that the homeless mentally ill person is a victim of inept and uncaring bureaucracies that place "rules" and financial stringency above the human consequences.

Bennett, D., and Morris, I. (1983). Deinstitutionalization in the United Kingdom. International Journal of Mental Health, 11(4), 5-23.

Presents a description of deinstitutionalization in the U.K. Remarkable in the number of parallels in the issues (impacts on neighborhoods, families, community support programs, costs) that occurred in the UK and U.S.A.

Bogue, D.J. (1963). Skid row in American cities. Chicago: University of Chicago.

Classic study of skid row which formed a major intellectual foundation for the removal of SRO's flop houses, etc. in the Urban Renewal program of the 1960's. The focus is on the deviance of the residents of skid row, methods of control, reform and elimination. Notable are the views that there are few women on skid row and that the mentally ill are identified (by police counts, etc.) and removed to hospitals.

Booth, W. (1890). In darkest England and the way out. London: Salvation Army.

A significant background resource in that much of the Salvation Army approach is illuminated by Booth's description and emphasis of the problem. The book's strong position on detention should be understood in the light of the then current vagrancy laws (i.e., vagrancy as a status offense).

Brantner, J.P. (1959). Homeless men: A psychological and medical survey. Unpublished doctoral dissertation, University of Minnesota. Ann Arbor U Microfilms [Microfilm AC-1-59-1253]. Dissertation Abstracts, 19(11), 3018-3019.

A useful historical comparison. The author notes the major health problems of long term alcohol abuse and deprivation.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J.E., Johnson, S., & Shore, M.F. (1981). Overview: Deinstitutionalization of psychiatric patients; A critical review of outcome studies. American Journal of Psychiatry, 138(6), 736-749.

Examines the successes and failures in deinstitutionalization. Identifies behavioral problems on the part of patients and mismatches with providers as the major sources of failure. The author concludes that successful deinstitutionalization depends on availability of appropriate community care.

Burnett, A., & Moon, G. (1983). Community opposition to hostels for single homeless men. Area, 15(2), 161-173.

Community opposition to a homeless hostel [shelter] derived from the neighbor's fear of alcohol, violence and destitute individuals being on the street. Although this is an English example it provides a detailed case study and a strong parallel to Dear's (1982) description of opposition to community mental health facilities.

Chicago Coalition for the Homeless. (1983). When you don't have anything. Chicago (P.O. Box 2751, Chicago, IL, 60690): Author.

Profile of homeless persons in Chicago in 1983. This study interviewed people who were homeless and gives both demographic and social information. Provides the "regional primate city" comparison for Wisconsin.

Chmiel, Andrew J., Akhtar, Salman, and Morris, Juanita. (1979) The long-distance psychiatric patient in the emergency room: insights regarding travel and mental illness. International Journal of Social Psychiatry, 25(1):38-46.

The motivational, demographic and clinical characteristics of individuals who seek psychiatric help at facilities located a great distance from their places of residence is discussed. Two groups (the first group is constituted by persons who, owing to their concerns with the social stigma of mental illness or driven by the desire for a magical solution to their problems, purposely undertake the journey to a distantly located psychiatric center and the second group consists of vacationers, hitchhikers, and skid row individuals) are identified. The results indicate that the long distance patients had a higher incidence of schizophrenia and alcohol related problems accounted for by the second group of long distance patients.

Cohen, C.I., & Sokolovsky, J. (1983). Toward a concept of homelessness among aged men. Journal of Gerontology, 38, 81-89.

Provides a modern theoretical sociological statement on the causes of homelessness. The authors emphasize disaffiliation as the root cause rather than inherent defect (such as unwillingness to work).

Collin, R.W. (1984). Homelessness: The policy and the law. Urban Lawyer, 16(Spring), 317-329.

Connor, J. (1983). Sheltering the homeless - for a model single room occupancy (SRO) for the homeless in Detroit. Paper presented at the hearing on Homelessness in America,. (Clare check)

An early proposal for a model SRO. This proposal has been frequently cited and debated in discussions as to the advisability supporting SRO accommodations. The paper presents the rationale adopted in many cities [San Francisco, NY, etc.].

Crystal, S. (1984). Homeless men and Homeless women: The gender gap. The Urban and Social Change Review. 17(2):2-6

Cuomo, M. (1983). 1933/1983--Never again: A report to the National Governors' Association Task Force on the Homeless. Albany, NY: State of New York, Executive Chamber. Reproduced in Subcommittee on Housing and Community Development (1984), pp. 353-443. [HV4504 .C86 1983]

This national study laid the foundation of the Governors' Association efforts on behalf of the homeless.

Dear, M.J. and S.M. Taylor. (1982). Not on Our Street: Community Attitudes to Mental Health Care. London: Pion.

A social science study of the impact of community mental health services on the local community.

Depp, F.C., and Ackiss, V. (1983, July 19). Assessing needs among sheltered homeless women. Paper presented at the conference "Homelessness: A Time for New Directions," Washington, D.C.

Reports on women using The House of Rath (Washington, D.C.). While many (95%) of the women had been treated for mental illness, higher proportions self-represented psychopathology (65%) and shelter staff believed (94%) to be in need of psychiatric evaluation and treatment. The shelter appears to be functioning as an element in the community mental health system.

Dolbeare, C. (1983). The low-income housing crisis. In C. Hartman (Ed.), America's housing crisis: What is to be done? Boston: Routledge & Kegan Paul.

Presents statistics on the recent decline in low-income housing and identifies the causes as; demolition (Urban Renewal, slum clearance), renovation (gentrification and resident upgrading) and conversion (to condominiums and offices). Notes that the prospect for significant private construction is limited by the relative unprofitability of low income housing when compared to other types of housing.

Downs, A. (1983). Rental housing in the 1980s. Washington, D.C.: Brookings Institution.

The author argues that low profitability limits rental accommodation supply while higher housing costs places increased pressure on the rental market from those who can not buy. The net result is low vacancy rates, higher rents and a growing inability of very low income households to afford housing.

Erickson, J. Wilhelm, C. (eds). (1986). Housing the Homeless.

A book of readings covering 1980-85. Several of the most significant papers of this period are collected in this book. There is a balance between papers by advocates and more pragmatic public policy approaches.

Fabricant, M. and Epstein, I. (1984) Legal and welfare rights advocacy: complementary approaches in organizing on behalf of the homeless. Urban and Social Change Reivie, 17(1):15-19, Winter.

A case study of a welfare advocacy effort on behalf of the homeless in Elizabeth, New Jersey. On the basis of this and other efforts, the complementary elements of legal and welfare rights advocacy are considered. In working with the homeless, the authors note, critics of legal advocacy have claimed that it is too time-consuming, too limited by the minimal standards of economic entitlement of present laws to deal effectively with root causes of the problem. Yet critics of welfare rights advocacy have argued that a case-by-case approach which exclusively provides immediate aid is too narrow in scope, fails to change legal and administrative frameworks, and that laws and bureaucratic procedures which provide the initial organizing opportunity become more constrained once fiscal pressure is applied. The authors suggest that legal and welfare rights are not mutually exclusive tactics, but instead complementary approaches which can address the immediate service needs of the homeless and provide a firm foundation for organizing in their behalf.

Foucault, M. (1968). *Madness and civilization*. New York: New American Library.

Although not intended as a discussion of the homeless mentally ill, this volume contains much historical information. Emphasis in on Europe, but because the U.S. inherited many of the policies developed in Europe this book is very useful background.

Freeman, Stanley J., Formo, Anton, Alampur, A. Gopala, Sommers, and A. Frank. (1979) Psychiatric disorder in a skid-row mission population. *Comprhensive Psychiatry*, Oct., Vol. 20(5), pp. 454-462.

Researchers administered a standardized psychiastric screening interview. Approximately 35% of the subsample of 60 SS could be categoup that made extensive use of a wide-range informal network of services.

Friedman, E. (1983). The light that failed: Psychiatric deinstitutionalization has betrayed its promise. *Hospitals Journal of the American Hospital Association*, *57*(16), 88f.

Posits that deinstitutionalization movement promised more than it could possibly provide. Lack of funding further limited the potential of the movement, but even with higher levels of funding deinstitutionalization would not have been a cooup that made extensive use of a wide-range informal network of services.

Friedman, E. (1983). The light that failed: Psychiatric deinstitutionalization has betrayed its promise. *Hospitals Journal of the American Hospital Association*, *57*(16), 88f.

Posits that deinstitutionalization movement promised more than it could possibly provide. Lack of funding further limited the potential of the movement, but even with higher levels of funding deinstitutionalization would not have been a complete solution.

Fry, Lincoln J. and Miller, Jon. (1975) Responding to skid row alcoholism: self-defeating arrangements in an innovative treatment program. *Social Problems*, 22(5):675-688.

The study identifies ambiguous and competing goals, conflicting vested interests, conflicts over organizational resources, and a lack of treatment technology as major sources of ineffectiveness in an innovative alcoholism treatment program located in a skid row mission. The agencies sponsoring this venture contributed to these problems, especially by their lack of planning and the large public expenditure actually diverted the treatment program from servicing one segment of its target population and indirectly contributed to the skid row alcoholism problem by introducing men to the area who might not otherwise have found their way there.

Garrett, Gerald R. and Bahr, Howard M. (1976) The family backgrounds of skid row women. Signs: Journal of Women in Culture and Society, 2(2):369-381.

The etiology of homelessness and excessive drinking of women who were both homeless and alcoholics were investigated. Data were gathered from life history interviews with 52 homeless women at a women's emergency shelter in New York City's bowery area and 199 male clients at an institution to which aged and ailing bowery men are voluntarily committed. Forty-four percent of the shelter women were black compared to 25% of the men. The women were more likely to be nativve born and better educated. Over half of the women, compared to 1/3 of the men, were reared in families where one or both parents were missing. Over 2/3 of the men cited a parental death as the reason for their broken home while the same percentage of women indicated a parental divorce, separation, or desertation. None of the respondents was living with a spouse at interview time but for most of those who had been married at least once, the marriage ended in separation or divorce. Over 75% of the women had been married compared with less than half of the men. Reported marital disagreements over the drinking of either spouse and over inlaws were significantly higher for the women. More than half of the women said that infidelity was a marital problem. The women were more likely to have large families than the men. It is concluded that the path leading to homelessness appears to be both qualitatively and quantitatively different for women than for men and that women from broken homes are in fact overrepresented among shelter women in comparison to other women as well as with skid row men. It is suggested that failure in marriage may be a key variable in explaining the "skid careers" of women while among homeless men it seems to play a minor role.

Gault, R.H. (1914). Pathologic vagrancy. Journal of Criminal Law and Criminology, 5, 321-322.

This book traces the development of working class housing, subsequent attempts at reform and regulations. Along with histories of social welfare tracing development of housing is an essential element in the background of modern homelessness.

Giesbrecht, Norman Abe. (1981) Changes in the drinking patterns of, skid row alcoholics. (Ph.D. Thesis) Dissertation Abstracts International, 41(7):3288-A (not available from Univ. Microfilms).

The concomitants of abstinence and controlled drinking among current and former skid row ineeriates were examined to study the normalization of deviants. Data were gathered from retrospective accounts of former and current male skid row inebriates on three main areas: current drinking behavior and major changes since the onset of heavy drinking, changes in other areas of experience, and the assessment of factors giving rise to abstinence or control. A strong relationship was found between current drinking status and either stakes in conformity or treatment experiences. The currently inactive drinkers were found to have a less negative view of how others had responded to them when they had been drinking heavily, were more likely to have been persistent in seeking out treatment contacts at that time, and more likely to have a positive assessment of their treatment experiences.

Goldman, H.H., Adams, N.H., & Taube, C.A. (1983). Deinstitutionalization: The data demythologized. Hospital and Community Psychiatry, 34(2), 129-134.

Reviews the status of deinstitutionalization and notes the following patterns; more people are denied admission and those admitted to hospitals are staying shorter periods leading to more people with mental illness living in the community.

Greenwood, Anthony A. (1975) Langley House Trust and the Problem of the Homeless Ex-Offender. Prison Service Journal (Reddich), 20:5-8.

A 240 bed community for homeless exoffenders is described in terms of goals, functions and limitations. The 12 house trust offers a caring, family like home where a man is asked to make a commitment in becoming a member of the family. Houses fall into three groups: halfway houses, fully supportive communities, and homes for retirement age men and others with no further work expectancy. The close relationship of each house with the probation service is discussed, and measures of success are reviewed. Records from one house indicate that after 5 years of existence, 43% of the men who had been residents settled down and took an honorable and stable place in society. Rejection of postsentence support by about 80% of homeless men leaving prison is noted, and reasons are posited for this reticence.

Gude, John. (1977) Accommodating the single homeless. (1977) Social Work Today (Birmingham), 8(34):10-13.

The Nottinghamshire lodging scheme is described with an account of its 4 year history. Although there have seen some difficulties in cultivating and retaining those landladies who are prepared to provide for the special needs of a group of single homeless exoffenders that includes alcoholics, severely nurotic and psychiatrically ill men, places have been found for all clients except for those requiring hospitalization. The operator in the lodging scheme acts as a liaison link between the probation officer and the landlady, and when accepting a referral obtains as many facts and impressions of the client as are necessary to suggest a lodging situation compatible with that client's needs. A wide range of lodging needs has been uncovered by the program including noncommercial accomodation for the mentally ill and addicted, and the development of supportive community type homes for females with children.

Hombs, M.E., and Snyder, M. (1982). Homelessness in America: A forced march to nowhere. Washington, D.C.: Community for Creative Non-Violence. [HV4505 .H65 1982].

Advocacy based book calling for government and private action to aid the homeless. Useful as background but much more detailed material is now available.

Hope, M., and Young, J. (1984). From back wards to back alleys: Deinstitutionalization and the homeless. Urban and Social Change Review, 17(2), 7-11.

Posits a causal linkage between deinstitutionalization and homelessness. Attributes this linkage to the desire to have "efficient" and "cost effective" social services and the vulnerability of the client population. The clients are seen as being powerless to resist deinstitutionalization or to demand adequate community care.

Hopper, K. (1985). The making of America's homeless: From skid row to new poor, 1945-1984. New York: Community Service Society.

Traces the changing nature of homelessness in modern America. Concludes that the modern crisis has become chronic so that it is now "normal" to have a homeless segment of the population.

Hopper, Kim, Baxter, Ellen and Cox, Stuart. (1982) Not making it crazy: the young homeless patients in New York City. New Directions for Mental Health Services, June, No. 14, pp. 33-42.

Examination of the causes of the increase in the number of young people who are mentally ill and homeless. Suggests that "denied admissions", "revolving doors" and "non-reach" (i.e., lack of outreach activities) together lead to non-involvement with the mental health system and increased vulnerability to homelessness. Researchers suggest that without decent, safe, accessible shelter, therapeutic efforts are fruitless.

Kanskie, N. (ed). (1985). Poverty in Wisconsin: proceedings of a conference held Nov. 30, 1983. Madison: Applied Population Laboratory, University of Wisconsin-Madison. [HB 935 W6 W5 80-3].

Collection of recent papers. Notes that while Wisconsin is relatively wealthy (compared to the U.S.) the national trends of removal of low cost housing, higher unemployment and social service problems are also present.

Kasinitz, P. (1984) Gentrification and homelessness: the single room occupant and the inner city revival. Urban and Social Change Review, 17(1):9-14, Winter.

Examines the process whereby gentification removes low cost housing units from the housing market by "promoting" units through renovation to medium and high cost segments of the market. The downtown areas of many American cities have undergone extensive renovation and revitalization in recent years; this "back to the city" or "gentrification" movement has been both acclaimed as an urban renaissance and accused of destroying urban neighborhoods and displacing inner city residents. The author is concerned with the effect of the rapid increase in the desirability of city land on what is usually considered the least desirable housing stock in the country: single-room occupancy hotels, rooming houses, and shelters. While the author attributes at least part of the rise in homelessness to gentrification there is no evidence presented to link the removal of SRO housing etc with gentrification efforts.

Kates, B. (1985). The murder of a shopping bag lady. San Diego: Harcourt Brace Jovanovich.

Recounts the events in the life of a woman - an immigrant who worked at low paid jobs, never married, cared for her parents and petty criminal brother and was diagnosed schizophrenic, who was murdered in NYC. While her story is unremarkable, the book is essentially a case history - one of the few available.

Kaufman, N.K. (1984) Homelessness: a comprehensive policy approach. Urban and Social Change Review, 17(1):21-26, Winter.

The Massachusetts policy on homelessness involves activating all appropriate agencies (public and private) to actively serve the homeless. Long run activities (such as providing low cost housing) are initiated while short run emergency shelter is pursued. The author considers how Massachusetts has attempted to deal with the causes and effects of homelessness in as comprehensive a manner as possible. Massachusetts is seen to have adopted a decentralized inter-agency approach in order to ensure that the state's response to homelessness will be built on the special features of each geographic area of the state. The state sees its role as developing policies which aid local communities in filling the gaps as they become evident at the local level. While the role of the state is crucial, there are also roles for local government, United Ways, churches, and synagogues; the problem of homelessness is too complex for any one group to tackle by itself.

Komisar, L. (1977). Down and out in the USA: A history of public welfare. New York: New Viewpoints.

Traces the development of the modern welfare system in the

U.S. The major focus is the linkage between reform movements, welfare programs and increasing bureaucratization.

Kondratas, S.A. (1985). *A strategy for helping America's homeless*. Washington, D.C.: Heritage Foundation.

One of the few "Reganomics" statements on homelessness. The report suggests that private charity should be used for the "truly needy" while the undeserving should not be aided. Any long run solution is seen as coming from a "dynamic" "expanding" private sector providing jobs.

Lamb, R.H. (1984). Deinstitutionalization and the homeless mentally ill. *Hospital and Community Psychiatry*, *35*, 899-907.

The author notes that deinstitutionalization has worked well but failures have occurred (some of the failures resulting in homelessness). Failures are of two kinds; 1) system failures where the community services necessary to support the person with mental illness were, not set up, poorly financed, poorly managed, or otherwise inadequate; 2) placement failures where the individual was inappropriately placed (ranging from "dumping", to inappropriate program placement).

Leaf, A., and Cohen, M. (1982). *Providing services for the homeless: The New York City program*. New York: Human Resources Administration. (250 Church St., NY, NY, 10013).

Leepson, M. (1982). The homeless: Growing national problem. *Congressional Quarterly*, pp. 795-812. [*Editorial Research Reports*, *2* (16)]

The steady growth in the number of homeless is seen as a result of social policies (deinstitutionalization, benefit cut backs, eligibility rule changes) and a weak economy.

LeGates, R.T., and Murphy, K. (1984). Austerity, shelter and social conflict in the United States. In W. K. Tabb & L. Sawers (Eds.), *Marxism and the metropolis* (pp. 123-151). New York: Oxford University Press.

Lincoln, S.J. (1980, July). Single-room residential hotels must be preserved as low-income housing alternative. *Journal of Housing*.

Author describes the portion of the housing market accessible to low income persons as facing losses from urban renewal, gentrification and conversion. The need to preserve. SRO housing as an element of the low income housing stock stems from the need for various kinds of housing to meet the diverse needs and ability to pay of the very poor.

Locke, H.J. (1935). Unemployed men in Chicago shelters. *Sociology and Social Research*, *19*, 420-428.

This study done at the height of the Depression provides a remarkable parallel to contemporary studies of destitute men.

Among the men studied average subpopulation was able and willing to work (%), another able but unwilling to work (%) while a third were unable to work (%).

Marcus, S. (1981). Financing residential hotel improvement: New York City. New York: Mayor's Office of SRO Housing. Committee on Banking, Finance and Urban Affairs (1983), Homelessness in America (No. 97-100). Washington, D.C.: U.S. Government Printing Office.

Presented as a proposal this plan involved creative financing options such as:

1) City purchase and renovation of properties with eventual "land over" to private charities.
2) Private renovation using city "grants" with guaranteed "contract of service" for shelter of the homeless.
3) "Rotting capital" where seec money would be used for the first renovations and cost savings or profits would form the basis for further renovations.

Maz, V., founder, House of Ruth, Washington, D.C. (1983). Committee on Banking, Finance and Urban Affairs, Homelessness in America (No. 97-100). Washington, D.C.: U.S. Government Printing Office.

Describes a large urban shelter/transitional facility for women in Washington, D.C. Women who enter the program have intensive case management to secure services, find housing and employment (if appropriate). A large proportion of the women have some form of mental illness. While the shelter is intended as an emergency and tarnsitional housing facility it has become part of the community support system.

Miller, R. (1981). The demolition of skid row. Lexington, MA: Lexington Books.

The demolition of skid row was once (1960's) seen as inevitable and idea solution to the problem of substandard housing. While urban renewal removed much of the SRO and cubical hotels, incomes of the very poor have not risen sufficiently to enable the poor to attain significantly better housing.

Moore, Harvey A. and Yegidis, Bonnie. (1982) Nobody's clients: females, alcohol and skid row. Journal of Drug Issues, Sum. Vol. 12(3), pp. 251-258.

Interviewed a group of 45-69 yr. old women found on "skid row" (in Tampa, St. Petersburg, and Sarasota, Florida) and studied police arrest records over 1 mo. to examine the dynamics of this culture. SS' social identity seemed to be organized around their moral or sexual deviance, since they were looked upon as prostitutes rather than as vagrants or alcoholics. Research on female alcoholic patterns and the enduring presence of females on skid row is reviewed in light of the development of social services for this subpopulation. (36 ref.)

Norton, R.D. (1983) Reindustrialization and the urban underclass. Hicks, D.A. and Glickman, N.J., eds. Transition to the 21st century: prospect and policies for economic and urban-regional tarnsofrmation. Greenwich, CT: Jai Press, 1983, pp. 181-203.

The single most critical test of central-city poverty, the author states, is federal urban policy. In spite of recent downtown revivals, the proverty count for central-city blacks rose by over one million people during the 1970s, signifying the failure of the dominant place-oriented urban strategy that has prevailed since the mid-1960s. A new strategy to fight urban poverty and underemployment can be effectively harmonized with the equality critical objective to revitalizing the American economy, the author contends; doing so, however, will demand a shift in emphasis from the useless place-orineted strategy to one of more direct assistance to distressed people--and that entails an end to both federal and local practices that currently link the underemployed to declining areas. The author calls for a people-to-jobs or mobility strategy that can serve two crucial purposes: (1) opening up new opportunities for the minority poor and for structurally displaced workers in general; and (2) serving the objective of enhanced flexibility--a heightened capacity to adapt to change--in the economy of the United States.

Otto, S., and Orford, J. (1978). Not quite like home: Small hostels for alcoholics and others. Chichester, England: John Wiley & Sons.

Reviews British models of housing. Falling between U.S. group homes and SRO accomodations. The small hostels are similar to small Y's. They provide some supervision and support but the emphasis is an accomodation rather than theraputic settings.

Overend, W. (1983, December 30). Mentally ill overtaking alcoholics on skid row. Los Angeles Times.

Notes that the number of mentally ill persons has grown to exceed that of the alcholics on skid row in Los Angeles. Many of the service agencies are consequently having to deal with a population with which they have little experience.

Patrick, J. (1979). Staff reactions to the closing of a community mental health center. Hospital and Community Psychiatry, 30, 259-262.

As budgets are constrained some communities are experiencing a re-centralization of community support programs. The staff of the centers that are closed show marked demoralization because they see the closings as a failure of the CSP model of treatment and with increasing work load are less able to serve their clients.

Parker, E.O. (1984). Medical care for the homeless. Journal of the American Medical Association, 252(6), 766.

The author notes that health care for the homeless is generally inadequate while the need is higher than in the overall population. The homeless present with both acute health care needs (trauma, exposure, etc.) and chronic problems (often severe due to lack of treatment). The need for innovative outreach and preventive care is discussed.

Pina, G.M. (1983). Housing is a right. Copenhagen: Royal Danish Academy of Art, School of Architecture, Foreign Students Department. p[HD7324.A3 P54 1983]

The author makes the case that housing is a human right. Housing in this case is seen as more than a shelter. Rather "housing" is defined as having some permanence and privacy.

Peterson, Iver. "Homeless Crisscross U.S. Until Their Cars and Their Dreams Break Down." New York Times, December 15, 1982, p. A16.

Documents the group of people (usually young unemployed, often families) who drive from one city to another seeking work. When their car breaks down, they are stranded often hundreds of miles from their origin community.

Priest, Robert G. (1978) The epidemiology of mental illness: illustrations from the single homeless population. Psychiatric Journal of the University of Ottawa, March, Vol. 3(1):27-32.

Epidemiological studies have consistently shown high rates of mental illness (particularly schizophrenia) in the centers of cities and in association with low socioeconomic status. It was predicted that there should be excessive psychiatric morbidity among the single homeless population. This was confirmed (by clinical judgement, the symptom-sign inventory, and the brief paired associate learning test) in 79 SS from this population in Edinburgh (with schizophrenia the most frequent diagnosis) and in 50 SS from Chicago (where alcoholism was more common). A sample of homeless men presenting to Edinburgh hospital services predominantly displayed severe personality disorder, and was younger, mobile, and generally unrepresentative of the general homeless population. Other studies are discussed in relation to the conclusion that the epidemiological findings on schizophrenia demonstrate the effect of the illness , rather than highlighting its causes. (40 ref.)

Reckless, W.C. (1934). Why women become hoboes. American Mercury, 31(February), 175-180.

This depression study indicates that women become homeless transiets either 1) as part of a couple where both are unemployed, or 2) as a single woman who, because unemployed or lost her economic support (usually through family dissolution).

Rhoads, Joanne. (1981) Rainbow Retreat, Inc., Phoenix, Arizona. Matlins, S. Services for Children of Alcoholics, Washington, GPO, DHHS Pub., No. (Adm) 81-1007, 191 p. (p. 164-176).

Services offered by Rainbow Retreat, Inc. in Phoenix, Arizona, which was opened in 1973 as an emergency shelter for abused wives and children in alcohol related situations, and which have been expanded to permit acceptance of those fleeing any abusive circumstances, are described. A primary alcoholism prevention program provides support and guidance through one-to-one and group activities for youth involved in alcoholic environments, offers young people group experiences in communication and self-understanding; provides parents guidance and education in effective parenting techniques, and shelter for children and motehrs who have experienced alcohol abuse within their families. Programs for residential, daycare, and drop-in clients include individual counseling, rap sessions, art and music activity groups, story time groups, and structured play. The residential shelter and treatment programs for abused or neglected children is designed to provide a family atmosphere and positive environment as a model for changing behaviors, attitudes, and values. The main goal of this component is to keep the family together as a unit, often with the women as head of household. Elements of the daycare program and community youth groups are examined, as are factors that should be included in program/client evaluation and design.

Ribton-Turner, C.J. (1887). A history of vagrants and vagrancy and beggars and begging. London: Chapman and Hall.

Perhaps the most influential book of the period. It summarized the development of the British treatment of the destitute and the then (1880's) position in Britain. This book provided the intellectual "backbone" of the reform movements (both U.K. and U.S.) of the 1890's. Coupled with "advocacy" publications, such as Booth, it provided a rationale for change so clearly indicated in the "advocacy" documents.

Riis, J.A. (1890). How the other half lives. Republished with introduction 1970, ed S.B. Warner. Belknap Press of Harvard U.P.

Based primarily on New York City this strongly argued book was a major factor in the housing and poor refore movements of the 1890's. By presenting the human consequences of inhuman living conditions, Riis communicated to the urban middle class the urgency of the situation. Many of his recommendations (tennement reform, sanitation, building codes, etc.) were later enacted in major American cities.

Rooney, James F. (1976) Friendship and disaffiliation among the skid row population. Journal of Gerontology, 31(1):82-88.

Studies of social relations of skid row men which have utilized theories of complete disengagement and of replacement of old friends by new are discussed. Data from interviews with 304 Philadelphia skid row residents upheld the theory of replacement. There was, however, a decline in the number of friends reported after the age of 70 and after 20 years of residence in the area. The loss of relationships was more closely associated with length of residence in skid row than with age. Qualitative measures of personal relationships indicated no major association between sociability and length of residence in skid row but a small association with advancing age. The proportions of friendless men desiring either friends or causal acquaintances were not related to either age or length of residence. It is concluded that these findings fail to uphold the disaffiliation hypothesis of aging and run counter to Vexliard's postulate of loss of need for meaningful personal relationships with increased exposure to the life of an outcast. (23 refs.) (Author abstracted modified.)

Rooney, J.F. (1980). Organizational success through program failure: Skid row rescue missions. Social Forces, 58(3), 904-924.

Author posits that skid row missions become organizational success by having programs that fail. The users of these failed programs become an ongoing pool of clients which keep the programs active.

Rosnow, M., Stapleton Concord, C., and Shaw, T. (1985). Listening to the homeless: A study of homeless mentally ill persons in Milwaukee. Final report of the Milwaukee Homelessness Research Project.

An extensive study of mentally ill homeless people in Milwaukee, including a comparison with a similar group who were involved with a community support program.

Rousseau, A.M. (1981). Shopping bag ladies: Homeless women speak about their lives. New York: Pilgrim Press.

This book includes photos and interviews with women who are homeless in New York City. It documents how they came to be homeless as well as their daily living strategies.

Reich Robert and Siegel, Lloyd. (1978) The emergence of the bowery, as a psychiatric dumping ground. Psychiatric Quarterly, 50(3):191-201.

The rising number of former mental patients in the decaying bowery section of New York following the drastic reduction of the New York state hospital population in the last decade which led to a demographic relocation of the mentally ill, rather than any real decline in the rate or severity of mental disorders, is described. Unable to function on their own in society and without adequate supportive facilities available, many discharged patients live in the streets and eventually end up on the bowery, where they are carried for at the men's shelter. Studies have shown that over 50% of the current bowery population has a history of mental illness and that alcoholism is often a secondary, rather than primary diagnosis. The most frequently encountered diagnostic syndromes are mentioned and commented upon. Possible alternative treatment interventions are suggested. (4 ref.) (Author abstract modified.)

Salerno, D., Hopper, K., and Baxter, E. (1984). Hardship in the heartland. New York: Community Service Society of New York, Institute for Social Welfare Research. (Detroit, Cleveland, Cincinnati, Milwaukee, Madison, Chicago, Denver, Tulsa). [HV4045.5.A14 S25 1984]

Scott, N.J., and Scott, R.A. (1980). The impact of housing markets on deinstitutionalization. Administration in Mental Health, 7(3), 210-222.

Segal, Steven P., Baumohl, Jim, and Johnson, Elsie. (1977) Falling through the cracks: mental disorder and social margin in a young vagrant population. Social Problems, 24(3):387-400.

A study was undertaken in order to investigate the incidence of psychiatric disorder and treatment of a distinctive, emerging young vagrant population. Twenty-two percent of a young vagrant population reported on in this study, and believed to be representative of similar groups in many American cities, have been hospitalized for psychological disorder. These young mentally disordered vagrants are the most marginal members of the vagrant subculture, lacking social margin (i.e., resources, relationships, and a credible identity) with their families, community services, and their peers. Their critical lack of social margin is due to an incongruence of expectations between disordered vagrants and potential benefactors. This incongruence generates a situation in which apparently eligible clients fall or slip through cracks in the service system. Ultimately, these individuals will become the core of a new chronically disordered and dependent population housed, at best, in community based sheltered living arrangements as they grow older. (Author abstract.)

Segal, Steven P. and Baumohl, Jim. (1980) Engaging the disengaged: Proposals of madness and vagrancy. Social Work, 25(5):358-365.

The characteristics, problems, and obstacles to humane community care of the chronically dysfunctional deinstitutionalized mental patient are discussed with reference to a California field study of "street people". These cases represent that portion of the expatient population which is characterized by delusionary, unpredictable, and unreliable behaviors, minimal occupational skills, and consistently poor judgement in financial management and interpersonal relations. Six conditions constitute significant obstacles to the community reintegration and care of space cases: transience, burden to the community chosen, inappropriate services, negative public attitudes, their proneness to victimization often involving violence, and chronicity. Recommendations for dealing appropriately with these obstacles are presented which could enhance the social integration of such cases through the development of stabilizing social supports that will function in lieu of distrupted social networks.

Smith, A.C. (1975). Desperate admissions. World Medicine, 10(13), 92-93.

Discusses the role of hospitals as providers of shelter to individuals with non-acute health care needs. Considers the advisability of "desperate admissions" sought by some homeless people.

Smith, J.C., and Hanham, R.Q. (1982). Deinstitutionalization and community acceptance of the mentally ill in the U.S.A. Ekistics, 49, 358-368.

Author discusses the resistance to mentally ill persons and facilities in U.S. communities.

Sommer, Robert and Osmond, Humphry. (1981) Journal of Orthomolecular Psychiatry, 10(3):193-201.

Results of deinstitutionalization of former mental patients are examined. Too often, it is argued, reformers followed the cry to shut down the large ineffective state hospitals, but not the demand to replace them with small active treatment community programs. Rather, the communities to which the former mental patients are released are not their original communities, but economically marginal areas where support services are not available. Cases are cited of former mental patients committing murder following their deinstitutionalization. Often, it is noted, these people should not have been released from mental hospitals, and yet, following their crimes, they will be incarcerated in jails with no mental health services. The closing of state mental hospitals has led to the crowding of jails and prisons with former mental patients or those who need mental health care. It is proposed that psychiatric reformers should direct their attention to the plight of the impaired street people and the mentally disturbed in jail.

Stern, M.J. (1984) The emergence of the homeless as a public problem. Social Service Review, 58(2):291-301, June.

During the 1980s, homelessness emerged as a significant public problem. Much confusion exists about the nature of this problem, who the homeless are, and what can be done about them. The author addresses these questions from an unusual perspective. Rather than concern for the facts about the homeless, he is concerned about how the homeless have been conceptualized in the public's mind and what this tells us, not about the homeless, but about ourselves, our officials, and our society. He uses the homeless as a means of looking at our society. First, he examines the past two years to see how the homeless have become a public problem at the national level, and as a local issue in the city of Philadelphia. Second, he places the homeless in a historical perspective and speculates about the historical significance of the emergence of this issue. He argues that the homeless as a public problem reflect the conservative drift in public policy symbolized graphically by the Reagan administration's attack on the poor.

Stapleton Concord, C., Barry, B., Schwichtenberg, R., and Hagerman, C. (1985). Homeless in an All-American City: Report of the Shelter the Homeless Task Force of the Madison Urban Ministry.

Reports on a drop-in shelter in Madison, in the Winter of 1984-85, which emphasized a "soft entry" approach to linking homeless people with services.

Stoner, M.R. (1984) An analysis of public and private sector provisions for homeless people. Urban and Social Change Review, 17(1):3-8, Winter.

Homelessness is an old and malignant problem in the United States which has reached critical levels in virtually all major cities; it has been reported that there are 36,000 homeless people in New York City. The number of homeless people has swelled tremendously with the recession/depression and drastic cutbacks in publicly funded social services. Homelessness may be a permanent and to some extent untreatable problem, but that hypothesis cannot be tested while existing public and private welfare policies preclude there being sufficient service delivery for the homeless population. The author reviews the types of programs that have arisen, or existed prior to the public outcry against homelessness in 1981 (with the publication of the New York City figure), to deal with the problem. A range of explanations about who the homeless are is offered, along with what appear to be the causes of their condition. Recommendations are made for a systematic approach to meet the homeless people, and an assessment is made of recent government attempts at solutions to the problem.

Test, M.A., and Stein, L.I. (1978). Community treatment of the chronic patient: Research overview. Schizophrenia Bulletin, 14(3), 350-364.

Description of the Dane County PACT program which includes intensive and agressive outreach with training in community living.

Urban Underclass, The. Society 21(1):34-86, Nov./Dec. 1983.

Wallich-Clifford, A. (1976). Caring on skid row. Dublin: Veritas.

One of several books documenting the Simon program of rehabilitating "destitute" individuals. The program is based on small housing units where the individuals are a mixture of residents and caretakers, but with a strong goal structure (which includes eventual placement in permanent independent housing - if appropriate). This program is not unlike the Dorothy Day Houses program in the U.S. in the 1940's and 1950's.

Williams, R.M. (1977). From bedlam to chaos: Are they closing the mental hospitals too soon? Psychology Today, 10(12), 124-129.

Author suggests that there is still a role for mental hospitals and that permature closing may lead to expensive re-opening in the future.

Watson, S. (1986). Housing and homelessness. London & Boston: Routeledge & Kegan Paul.

States. Urban scholars such as William Julius Wilson, Elijah Anderson, John D. Kasarda, Ira Katznelson, William Darity, Jr., David Whitman, Diana M. Pearce, and John U. Ogbu discuss such issues as racial and class boundaries, female poverty, changes in the employment base of cities, politics in the cities, education, immigrant populations, and inner-city dislocation. In an introduction entitled Inner-City Woes, William J. Wilson points out that since 1970, public attention to the problems of the inner-city has waned and that by the close of the twentieth century, the current problems of social dislocation will lead to a potentially explosive situation in the United States. In spite of a period of unprecedented civil rights activity and antidiscrimination legislation and socioeconomic position of the urban underclass has deteriorated. This suggests that the impact of forces not specifically race related need to be considered. Several authors argue that social organization is a strong factor in the problems of the under-class.

U.S. House of Representatives, Committee on Banking, Finance and Urban Affairs, Subcommittee on Housing and Community Development. (1983). *Homelessness in America* (Report of hearings held December 15, 1982, Serial No. 97-100). Washington, D.C.: U.S. Government Printing Office.

This report of the first major hearing in the 1980's, contains many city reports reprinted as part of the submissions.

U.S. House of Representatives, Committee on Banking, Finance and Urban Affairs, Subcommittee on Housing and Community Development. (1984). *Homelessness in America II* (Report of hearings held January 25, 1984 and appendices, Serial No. 98-64). Washington, D.C.: U.S. Government Printing Office.

Follow up to the 1982 hearings this report again contains many individual city reports.

U.S. General Accounting Office. (1985, April 9). *Homelessness: A complex problem and the federal response [Report]. Washington:* Author.

A review of individual city studies completed between 1980 and 1983.

U.S. Conference of Mayors. (1984). *Homelessness in America's cities: Ten case studies*. Washington: Author.

Wallace, S.E. (1965). *Skid row as a way of life*. New York: Harper & Row.

Based primarily on participant observation, this study includes material on Minneapolis. The author seems to both document and explain skid row in terms of the "deviance" and/or "failure" of the individual.

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Present Condition of the Sheltered Homeless Population: Wisconsin 1985

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PRESENT CONDITION OF THE SHELTERED HOMELESS POPULATION: WISCONSIN 1985.

Introduction

Planning programatic initiatives for the homeless population of Wisconsin presents difficulties because, to date, there has been no statewide attempt to systematically assess the situation of the homeless population. The documentation of the number of persons who are homeless is perhaps not as important as other information such as the accessibility, cost, and conditions under which emergency shelter is provided. Obtaining such information is critical to assessing both the nature of the homeless problem and the capacity of agencies to respond appropriately. This research attempts to to establish a statewide data base on emergency shelter to assist in policy planning for the homeless population.

A survey designed to collect a common set of information on programs which provide shelter directly or indirectly (through vouchers etc), was sent to all known providers in Wisconsin. The survey also sought provider's comments and opinions on the major unmet needs and recommendations that they might have on meeting those unmet needs.

Questionnaires (along with a stamped self addressed return envelopes) were sent to 45 agencies identified as part of the Department of Health and Human Services program for shelter providers in Wisconsin. Subsequent telephone follow-up encouraged non-responding agencies to complete the survey. Second mailings were made when necessary. Some of the personnel who could provide the requested information were involved in meetings, working with clients, or unavailable due to part-time or variable work hours. Telephone interviews were necessary to secure responses from these providers. Although the survey was somewhat cumbersome to administer by telephone there appears to be little or no difference between the responses mailed back versus those obtained over the telephone.

There was only one absolute refusal to provide any information. The refusing agency in southeastern Wisconsin is religious in nature and provides an evening meal and shelter to males only. One other director refused to give any estimates of client characteristics because he did not want to provide any misleading information. This agency does not keep any records. The director believes that any inaccurate information could be detrimental to those who are homeless. In addition to these two agencies, two providers had ceased operation and two were excluded (because they provided specialized services which were beyond the scope of this project). Seven other agencies provided information and referral services only, and although their information contributes to the overall perspective of this report they are not included in the calculated statistics.

A word of caution is in order at the outset of this report. The majority of agencies did not have the kind of information and data the survey requested. While most agencies record some information, the majority keep little more than name, dates, precipitating events and occasionally demographic data. The reasons behind this lack of record keeping are varied but include the low number of persons served (in rural areas) and the lack of a monetary incentive (until recently perhaps) to maintain more complete programmatic data. Their meager budgets and underfunding of their programs combined with limited staff attempting to serve those with vast needs makes record keeping seem arbitrary and even to hinder these agencies overall goals.

There were however several providers who did keep detailed records. For these agencies, record keeping has become integral to their funding procedures; as a consequence they are able to provide reliable and reliable and accurate data. The majority of these programs are also troubled by the same staffing limitations and have the added burden of a larger clientele, but have learned that data collection frequently leads to funding on various levels. The majority of these programs are located in Madison and Milwaukee.

The estimates obtained both in writing and via telephone represent the best current picture of the situation in Wisconsin. The intensive effort necessary to collect the information does however speak to the need for a common statewide database if we are to have accurate information capable of delineating changes and fluctuations over time in the homeless population of Wisconsin.

Although it is essential to bear in mind that many of these figures are estimates, they are not without merit. The providers made informed approximations when exact information was unavailable. Notwithstanding the limitations, the information contained in this report begins to lay the foundation upon which future research can be constructed.

There were thirty-nine providers included in the survey. Of these 12 provided direct service (DSO in the following tables), 19 provided shelter vouchers (VO in the following tables), six agencies provided both direct services and voucher services (DSV in the following tables), and two provided voucher services with a prevention aspect (VP in the following tables). The VP group is unique in that they not only provide voucher services, but also utilize their funds in such a way as to assist in paying rents, energy assistance and the like in an attempt to keep persons in their homes or apartments rather than waiting for them to become "technically homeless" and then provide lodging in a hotel for a night or two. These programs are grounded on the belief that it is easier and more cost effective to assist people while they are still domiciled.

Detailed results of the Survey of Shelter Providers in Wisconsin

1. A. Does your program operate year-round? Yes____ No____

If "No" when does it operate? ______________________________

B. Hours of operation: Day ____ Evening _______ Overnight______

One commonality among all the programs was that all operate year around. There were however notable differences in the hours of operation.

(See notes below)	Total	DSO N=12	DS&V N=6	VO N=19	VP N=2
Day Only	2			2	
Evening Only	0				
Day and Evening Only	6			6*	
Evening and Overnight	5	3	2		
24 hours	25	9	3	11	2
Some coverage (all with 24 hour emergency cover)	7		1	6*	

Notes: Figures in this table are numbers of agencies

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention
*	These 6 agencies provide day and evening hours and some additional coverage.

As would be expected, the direct service providers including those who additionally provide vouchers generally operate 24 hours a day. The remaining providers are open during evening hours (after 7 pm) and overnight due to the high demand for night-time shelter. Six of the agencies had day and evening hours, but were also able to provide some form of 24 hour emergency coverage.

2. Do you serve (please check)

______ males only
______ females only
______ families only
______ males and females
______ females and children

(See notes below)	Total	DSO N=12	DS&V N=6	VO N=19	VP N=2
No single males,but others	3	0	2	1	0
Males only	3	2	1	0	0
Females only	0	0	0	0	0
Males and Females only	2	2	0	0	0
Females and children	2	2	0	0	0
Families	35	6	9	18	2
Unaccompanied minors	0	0	0	0	0

Notes: Figures in this table are numbers of agencies

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

It is notable that there were no providers who served unaccompanied minors. Most of the agencies, while not providing shelter services, do provide unaccompanied minors with information and referral. This survey did not cover those providers directly targeting youth. Many youths who are homeless may find their way to runaway shelters and the like.

Also of note in the above table in the number of providers who serve families (more than one person in the group). Though many agencies do not target this group, services are for the most part available to families.

3. Please indicate the services which your program provides (or vouchers) to each of the specified types of clients:

	Provide Service			Provide Vouchers	
	Meals	Bed	Info/Referral	Meals	Bed
Single Adult Men					
Single Adult Women					
Unaccompanied Minors					
Women with Children					
Two-Parent Families					

With regard to meals, the typical pattern consisted of direct service providers offering meals on-site. Four of the direct service provider agencies that give vouchers for lodging also give vouchers for meals. All of the agencies that provide vouchers for lodging, provide vouchers for food as well. Only one provided meals directly in addition to their outside food sources. The two voucher/prevention programs also provided vouchers for meals.

Most agencies, whether direct service providers or those who provide vouchering services, indicated that they provide information and referral to everyone, regardless of their target population. Interestingly however, many reported that they rarely needed to do this because most clients were of the group(s) that the agency targeted, thus eliminating the need for information and referral services to non-targeted groups.

4. What percentages of your referrals of people who are homeless come from each of the following sources?

(See notes below)	DSO N=9	DS&V N=6	VO N=18	VP N=2
	%	%	%	%
community mental health programs	3	5	15	10
mental health hospitals	2	0	3	2
local Department of Social Services	19	29	25	33
police	15	7	20	15
other local governmental agencies	2	4	1	10
state agencies	3	1	0	0
private voluntary agencies	11	6	12	20
self referrals (walk-ins)	45	47	23	10
other (what?)	0	1	0	0

Notes: Figures in this table are percent of agency's clients

DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

As the above table reveals there is a great similarity among the programs in terms of where referrals originate. Voucher programs appear to have a broader base of referrals when compared to direct service providers. The direct service providers have a much higher number of walk-ins (self-referals) than voucher programs.

What is not evident from the table is that the smaller communities rely on the police for referrals, especially during late night hours. In these communities it is frequently the police who first become aware of persons in need of shelter. The larger communities (and consequently those reporting higher numbers of people who are homeless) obtain the majority of their referrals as walk-ins or from local Departments of Social Services and private voluntary agencies.

5. If you provide shelter directly, please complete the following:

	Individuals Only	Families Only	Either	Total
Listed capacity (# beds)	563	111	35	709
The largest number you sheltered on one night in 1985	558	62	35	655
The smallest number you sheltered on one night in 1985	214	10	18	242
The average number you sheltered on one night in 1985	362	36	25	423

Note: Figures in this table are numbers of clients (summed over all responding agencies).

Two agencies did not provide shelter during 1985 and thus are not included in this tabulation. Obviously voucher programs are not included. Two agencies did not distinguish between family or individual beds. They accommodate both families and individuals according to the needs of the day.

Some qualifications need to be made as to the number of 'beds'. Some agencies included cots, chairs, blankets and pillows on the floor, in the definition of beds or capacity. Thus the number of 709 reflects the upper limit of 'beds' for those agencies participating in this survey. The tested capacity of 655 is perhaps a better estimate of actual capacity. There is no assumption that the 'beds' or the filled-to-capacity shelter would comply with health and building codes.

Additionally, sometimes agencies must double or triple-up children in a bed due to lack of space. While the upper limit of the available beds has not been met, large families sometimes go unserved due to the difficulty in matching large families with suitable accommodation. For example, on a given night a shelter may be almost full. A family of six is in need of shelter but there are only three beds. Rather than split the family up some parents choose to stay together but unsheltered. For others there is no choice because of the prohibitions against sheltering unaccompanied minors. Thus parents who may be willing to forgo shelter for themselves can not leave the children in a shelter because they would then be unaccompanied minors.

A further qualification as to the number of beds involves the availability of those beds to persons without shelter. For example, the Dane County facility in Madison is not available to men who are not eligible for general assistance nor is it available to women (g.a. eligible or not). Thus there is the real possibility of beds being empty while people sleep outdoors or in overfilled, but more 'available,' shelters.

6. If you purchase or arrange shelter, please complete the following:

	Individuals	Families	Either	Total
The maximum number of such spaces available on any one night in 1985	74	72	31	178
The largest number for whom you purchased such lodging on one night in 1985	132	65	24	221
The smallest number for whom you purchased such lodging on one night in 1985	11	8	10	29
The average number for whom you purchased such lodging on one night in 1985	47	16.5	17	80.5

Note: Figures in this table are numbers of clients (summed over all responding agencies).

While only four agencies combined all their data for this question (making no distinction between beds for individuals or for families) the overwhelming majority of agencies made an arbitrary distinction. Three agencies served only individuals for purchasing or arranging shelter. Three other agencies did not have funds available for vouchering beds in 1985. Most agencies stated that the maximum number was unlimited because they were uncertain how many beds would be available in the hotels they utilize. Many reported that the maximum number of beds available was contingent only on the agencies' available funds for vouchering.

Four agencies mentioned that they had a permanent bed or two reserved for them every night with a particular hotel or motel. Respondents saw two advantages to this kind of arrangement. First, it is a practical solution to the constant, frantic searching for a space to put someone up for the night. Secondly, providers were able to get greatly reduced rate by renting a room for a whole month rather than on a nightly basis.

Although voucher providers estimated that the maximum number of spaces available was 178, the largest number actually sheltered was 221. This dicrepency arises from some programs overspending their budgeted number of spaces. In effect agencies budgeted for a high of 178 spaces per night but expended funds for 221 on the highest night.

7. Of the persons you serve, what percentage are in each of the following income groups? (persons may not be in these groups, so total may not sum to 100%).

Persons in Families

(See notes below)	Total=33		DSO =7		DS&V =6		VO =18		VP = 2	
	#	%	#	%	#	%	#	%	#	%
a. No income	1481	45	390	56	150	25	866	49	75	38
b. General Assistance	338	10	65	9	55	9	208	12	10	5
c. AFDC	1279	39	235	34	320	53	614	34	110	55
d. SSI	48	1	0	0	35	6	13	1	0	0
e. Retirement/Pension	2	0	0	0	0	0	2	0	0	0
f. Social Security /Disability	27	1	10	1	20	3	2	0	5	2
g. Unemployment Compensation	92	3	0	0	17	3	75	4	0	0
h. Plasma Center	3	0	0	0	3	0	0	0	0	0
i. Other (specify)	0	0	0	0	0	0	0	0	0	0

Single Persons

(See notes below)	Total=33		DSO =7		DS&V =6		VC =18		VP = 2	
	#	%	#	%	#	%	#	%	#	%
a. No income	2137	58	647	59	260	43	1080	60	150	75
b. General Assistance	993	27	208	19	225	37	510	28	50	25
c. AFDC	64	2	14	1	0	0	50	3	0	0
d. SSI	159	4	76	7	68	11	15	0	0	0
e. Retirement/Pension	57	1	42	4	5	1	10	1	0	0
f. Social Security /Disability	149	4	58	5	35	6	56	3	0	0
g. Unemployment Compensation	102	3	25	2	2	0	75	4	0	0
h. Plasma Center	27	1	18	2	5	1	4	0	0	0
i. Other (specify)	9	0	9	1	0	0	0	0	0	0

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

The majority of agency respondents attempted to answer this question, but only a few actually ask this question of their clients. Many providers reported that numerous clients came for services when an entitlement benefit failed to arrive on time, but the overwhelming majority have no income upon arrival. The apparent trend as can be seen from the data is that families tend to have somewhat more money and are more often eligible for AFDC than general assistance. Single persons, on the other hand, have less income and secure general assistance when possible.

Agencies usually begin immediately to assist clients in the securing of applicable benefits whenever appropriate. The most notable aspect of this table is the number of people who arrive at the provider agency with no income whatsoever. Shelter providers are not usually prepared to deal with the substantial immediate needs of persons who are totally destitute.

8. Of the persons you serve, what percentage are in each of the following groups? (persons may not be in these groups, so total may not sum to 100%).

Persons in Families

(See notes below)	Total=31		DSO =6 (DK=2) (NA=4)		DS&V =5 (DK=1)		VO =18 (DK=1)		VP = 2	
	#	%	#	%	#	%	#	%	#	%
a. Mentally Disabled	289	9	110	15	122	26	57	3	0	0
b. Physically Disabled	51	2	10	1	10	2	11	1	20	10
c. Substance Abusers	395	12	110	15	140	30	145	8	0	0
d. Domestic Abuse Victim	504	16	79	11	140	30	245	13	40	20
e. Migrant/Seasonal Workers	99	3	25	3	20	4	54	3	0	0
f. None of the above	1854	58	381	53	35	7	1298	72	140	70

Single Persons

(See notes below)	Total=33		DSO =7		DS&V =6		VO =18		VP = 2	
	#	%	#	%	#	%	#	%	#	%
a. Mentally Disabled	716	20	295	26	162	32	254	14	5	2.5
b. Physically Disabled	76	2	52	5	17	3	2	.	5	2.5
c. Substance Abusers	965	26	401	36	174	34	365	20	25	12.5
d. Domestic Abuse Victim	117	3	51	4	6	1	60	3	0	0
e. Migrant/Seasonal Workers	185	5	40	3	25	5	115	6	5	2.5
f. None of the above	1585	43	276	26	121	24	1028	56	160	80.0

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Purchase

Most providers estimated their responses to this question. The most frequent response explaining "none of the above" was "just simply poor". While many persons are "just simply poor" there are significantly more families classed "just simply poor" than individuals. The above table shows that individuals tend to have additional complexities in their lives such as poor mental health and actively abuse substances (primarily alcohol).

There is a marked contrast in the responses of agencies providing direct services and vouchers and those providing vouchers only. Both persons in families and single individuals with mental disabilities are much less likely to be seen by voucher only agencies. On the other hand these agencies tend to have more 'simply poor' persons in the population that they serve. To the extent that voucher only agencies tend to be the only source of emergency shelter in the more rural counties, this finding may suggest at least three alternatives. First that persons with mental disability are not as vulnerable to loss of their housing in these areas. Second that the person who is homeless and mentally disabled is not in the agency's target group in terms of emergency shelter. Third, that these agencies in assigning priorities to those whom it will serve place the 'simply poor' above those with more complex problems.

9. **What percentages of the persons you serve are in more than one of the above groups? (Mentally Disabled, Physically Disabled, Substance Abusers, Domestic Abuse Victim, Migrant/Seasonal Workers, None of the above (simply poor)).**

The majority of agencies were quick to point out overlapping categories, but only about half of respondents attempted to estimate percentages of the most frequent combinations. There were a few agencies however that were able to make fairly clear delineating distinctions. For all agencies reporting persons overlapping several categories, the most frequently occurring combination were those in the categories of mentally disabled and substance abusers.

This finding was most prevalent among those agencies that provide direct services only and in agencies that provide direct services in addition to vouchers. The programs only providing vouchers reported a more frequent combination of substance abusers and other (poor and unemployed). For these agencies persons in the categories "mentally disabled" and "substance abusers" appeared in a relatively distant second position, both in terms of overall agencies reporting this combination and the percentages reported. The data available on the two voucher programs is very minimal, but those persons being served tended to be either poor/unemployed and substance abusers, or poor/unemployed and victims of domestic violence.

Perhaps the major distinction between the various types of service providers was the disproportionate number of persons with mental disability and another problem reported by direct service providers. No other providers reported this combination with such frequency, or as higher proportion as the direct service providers.

10. Of the persons that you serve, what percentage are;

Persons in Families

	Total NA/DK=8 N=31	DSO N=2 NA/DK=7	DS&V N=6 NA/DK=0	VC N=16 NA/DK=1	VP N=2 NA/DK=0
A. Female	1899(63%)	365(73%)	365(61%)	1034(61%)	135(67.5%)
B. Male	1101(37%)	135(27%)	235(39%)	666(39%)	65(32.5%)

Single Persons

	Total N=39	DSC N=12 NA/DK=0	DS&V N=6 NA/DK=0	VO N=19 NA/DK=0	VP N=2 NA/DK=0
A. Female	1027(29%)	437(36%)	172(29%)	398(22%)	20(10%)
B. Male	2746(71%)	763(64%)	428(71%)	1402(78%)	180(90%)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VC	Voucher Providers Only
VP	Voucher and Purchase

Some agencies kept their records so intertwined that it was difficult and sometimes impossible for them to distinguish differences between those in families or as individuals. However the majority of agencies were able to report exact differences as it pertained to this question.

The ratio of females to males varies not so much by the type of service provider, but rather by the the grouping 'persons-in-families' or 'single persons'. Among persons in family groupings, the number of females is much higher than in the population of homeless single persons.

11. Of the persons who are homeless that you serve, what percentages are in each of the following racial/ethnic groups?

Persons in Families

	Total NA/DK=10 N=29	DSO N=7 NA/DK=5	DS&V N=5 NA/DK=1	VO N=15 NA/DK=4	VP N=2 NA/DK=0
a. Black	632(22%)	229(33%)	161(32%)	202(13%)	40(20%)
b. White	2027(70%)	417(60%)	308(62%)	1152(77%)	150(75%)
c. Hispanic	143(5%)	33(5%)	24(5%)	76(5%)	10(5%)
d. Asian	38(1%)	8(1%)	2(<1%)	28(2%)	0(0%)
e. Native American	48(2%)	7(1%)	4(1%)	36(2%)	0(0%)
f. Other	10(<1%)	5(<1%)	0(0%)	5(1%)	0(0%)

Single Persons

	Total N=43 NA/DK=3	DSO N=18 NA/DK=1	DS&V N=5 NA/DK=1	VO N=18 NA/DK=1	VP N=2 NA/DK=0
a. Black	618(17%)	331(30%)	49(9%)	188(10%)	50(25%)
b. White	2663(74%)	680(62%)	404(81%)	1434(80%)	145(73%)
c. Hispanic	166(5%)	55(5%)	21(5%)	87(5%)	3(2%)
d. Asian	38(1%)	9(1%)	7(1%)	21(1%)	1(<1%)
e. Native American	94(3%)	19(2%)	14(3%)	60(3%)	1(<1%)
f. Other	15(<1%)	5(<1%)	5(1%)	5(1%)	0(0%)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

The racial/ethnic mix in the people served was consistent accross various types of service providers. This finding holds-up even when controlling for the disparate sample sizes. The racial/ethnic backgrounds of the homeless population, evident from the above tables, mirror the overall geographical groupings within the state. In other words, in the northern parts of Wisconsin providers serve primarily

Whites and some Native Americans and Hmong/Asian persons. The highest concentrations of minorities in the homeless population occur in the southern portion of Wisconsin.

While the geographic pattern of minorities parallels that in the general population there is an over-representation of all minority groups when compared to the 1980 United States Census Profile for Wisconsin. Census data indicated that Whites comprise 94 percent of the state's population, with the next largest group being Blacks at four percent. The following table summarizes this over-representation.

	Whites	Blacks	Other Minorities
1980 Census	94%	4%	2%
1985 Sheltered Homeless Persons			
In Families	70%	22%	8%
Single Persons	74%	17%	9%

12. Of the persons who are homeless that you serve, what percentages are in each of the following age groups?

Males

	Total NA/DK=2 N=37	DSO N=10 NA/DK=1	DS&V N=6 NA/DK=0	VO N=18 NA/DK=1	VP N=2 NA/DK=0
a. Under 18	260(7%)	10(1%)	101(17%)	149(8%)	0(0%)
b. 18-25	1040(28%)	226(21%)	165(27%)	629(34%)	20(10%)
c. 26-30	1188(32%)	426(39%)	218(36%)	524(28%)	20(10%)
d. 31-60	1161(31%)	380(35%)	107(18%)	514(28%)	160(80%)
e. Over 60	86(2%)	48(4%)	9(2%)	29(2%)	0(0%)

Females

	Total NA/DK=3 N=36	DSO N=10 NA/DK=2	DS&V N=6 NA/DK=0	VO N=18 NA/DK=1	VP N=2 NA/DK=0
a. Under 18	277(8%)	17(2%)	75(12%)	185(11%)	0(0%)
b. 18-25	1102(31%)	237(24%)	215(36%)	640(37%)	10(5%)
c. 26-30	1029(29%)	385(39%)	170(28%)	464(27%)	10(5%)
d. 31-60	1062(30%)	337(34%)	135(23%)	410(24%)	180(90%)
e. Over 60	33(1%)	14(1%)	5(1%)	14(1%)	0(0%)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

The ages of the recipients was very consistent across various service providers. The majority of agencies had difficulty separating out the ages of males versus females, but frequently reported that they believed them to be equivalent. Based on various data records the best estimates yielded the above table which indicates little difference in ages between the sexes.

13. If the racial/ethnic or the age/sex percentages among clients you serve are different for certain "special needs groups", please indicate such differences on a separate sheet of paper (for example: if the substance abusers are nearly all teenagers, or the mentally disabled are more likely to be over age 60).

Insufficient responses were obtained to make any meaningful statements about this question.

14. Please estimate the percentage of your clients who are homeless and in the following categories:

a. Those requiring organized or institutional support programs (e.g., because of mental disability)

b. Those requiring limited support or cash assistance, not ready to take a job (e.g., untrained young mother with child)

c. Those temporarily homeless for economic reasons, needing a job but employable (e.g., a recently unemployed auto worker)

	Total N=39	DSO N=19	DS&V N=6	VO N=12	VP N=2
a.	627(16%)	232(12%)	171(28%)	209(18%)	15(7.5%)
b.	1541(40%)	788(42%)	235(39%)	453(38%)	65(32.5%)
c.	1707(44%)	880(46%)	194(32%)	513(44%)	120(60%)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Many respondents felt the need to qualify their answers to this question. They noted that these figures are all estimates and that some individuals fell into two categories - which were viewed as not mutually exclusive. In addition some providers believe that there is great disparity between families and individuals as it pertains to this questions.

In general the consensus of providers was that families tend to be in categories "c" and "b" respectively (and seldom in "a"). Thus providers saw families that were homeless due to the recent recession or to long term unemployment as a consequence of restructuring of the economy. Providers viewed individuals as more likely to be in category "a", but also in categories "b" and "c".

15. Do you ask your clients why they are homeless?

	Total N=36 NA/DK=2	DSO N=11 NA/DK=1	DSV N=6 NA/DK=0	VO N=18 NA/DK=0	VP N=1 NA/DK=1
Yes	36	10	6	18	1
No	0				

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Every provider elicits an answer, (directly, or indirectly) to this question. Often this occurs in an informal fashion. Because providers do elicit this information from each of their clients, their responses to the later questions on the causes of their clients homelessness can be viewed with some confidence.

16. Do you ask your clients where they came from?

	Total N=37 NA/DK=1	DSC N=11 NA/DK=1	DSV N=6 NA/DK=0	VO N=18 NA/DK=0	VP N=2 NA/DK=1
Yes	35	11	5	17	2
No	1	0	1	0	0
Depends on if it is an individual or family	1			1	

Again, because providers do elicit this information from each of their clients, their responses to the later questions on the source of their clients can be viewed with some confidence.

17. Prior to their becoming homeless, where did your clients live? Please estimate the percentage of your clients for each category:

	Total N=37 NA/DK=2	DSO N=11 NA/DK=1	DSV N=6 NA/DK=0	VO N=18 NA/DK=1	VP N=2 NA/DK=0
Lived:					
a. independently	2158(58%)	753(68%)	325(54%)	910(50.5%)	170(85%)
b. other's housing	945(26%)	231(21%)	134(22%)	550(30.5%)	30(15%)
c. institution	281(8%)	80(7%)	81(14%)	120(7%)	0(0%)
d. other passing through	316(8%)	36(3%)	60(105)	220(12%)	0(0%)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Numerous service providers noted that this question was quite difficult to answer especially for those who have been homeless for a considerable period of time. The "other" category was consistently answered as "just passing through", though some implied that these persons fit into categories "a" or "b", others commented that persons "just passing through" had been chronically homeless and providers did not know (nor did they ask) where they had last lived.

18. Where do your clients come from? Please estimate the percentage of your clients for each category:

	Total N=39 NA/DK=0	DSO N=12 NA/DK=0	DSV N=6 NA/DK=0	VO N=19 NA/DK=0	VP N=2 NA/DK=0
a. Own town or city	2151 (54%)	725 (61%)	335 (56%)	819 (43%)	180 (90%)
b. Other own county	779 (20%)	223 (19%)	124 (21%)	412 (22%)	20 (10%)
c. Other Wisconsin	507 (13%)	105 (9%)	78 (13%)	324 (17%)	0 (0%)
d. Non-Wisconsin	540 (13%)	132 (11%)	63 (10%)	345 (18%)	0 (0%)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

The majority of agencies provide services to those who are from their own town or city. Almost three quarters of persons are from the county in which the provider is located. It is the voucher-only programs that serve the more mobile individuals and families than other types of providers.

This local pattern of homelessness is typical of states without very large cities. People who are homeless tend to have little or no resources so are unlikely to be able to travel. Indeed some of the voucher-only programs commented that the out-of-town person was usually on the way to a definite destination (often family or job oriented), when they ran out of funds or were otherwise stranded. A study of one shelter (in Madison in the winter of 1984-85) indicated that the majority of people who were from out-of-state nonetheless had strong connectiosn with Wisconsin (usually they were born or grew up in Wisconsin).

19. What do you think was the primary cause of the client's becoming homeless? Please estimate the percentage of your clients for each category:

	Total N=37 NA/DK=2	DSO N=11 NA/DK=1	DSV N=6 NA/DK=0	VO N=18 NA/DK=1	VP N=2 NA/DK=0
a. evicted by landlord	1523(41%)	464(42%)	205(34%)	724(40%)	130(65%)
b. evicted by primary tenant in whose unit the person lived	595(16%)	146(13%)	117(20%)	292(16%)	40(20%)
c. destruction of housing unit	45 3%)	35(3%)	5(1%)	55(3%)	0(0%)
d. family disruption	686(19%)	209(19%)	155(26%)	292(16%)	30(15%)
e. discharge from mental health facility	155(4%)	60(5%)	26(4%)	69(4%)	0(0%)
f. discharge from detox facility	129(3%)	45(4%)	36(6%)	48(3%)	0(0%)
g. discharge from other institution (prison etc)	176(5%)	85(8%)	36(6%)	55(3%)	0(0%)
h. other- poor no money	340(9%)	55(5%)	20(3%)	265(15%)	0(05)

Notes: Figures in this table are numbers and percent of clients. Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Many providers indicated that most people are not actually evicted by either a landlord or by a primary tenant. The actual predecessor is lack of income to pay the rent, thus forcing them to leave. So, while most indicated categories "a", "b" and "h", the real factor was being poor and having to move on - to somewhere else. Family disruption was frequently cited as associated with lack of money.

In examining precipitating events it is important to look at the process of becoming homeless. For example, although destruction of housing unit or discharge from any type of institution accounted for 17 percent of the overall total, this figure may be an underestimate, given the element of 'time'. Thus, someone may have had their housing unit destroyed, prompting them to move in with a relative or friend until conditions necessitate that they "move-on". Likewise discharge from an institution may be part of a process which also involves loss of benifits and subsequent eviction for non-payment of rent. Unemployment, underemployment and delayed entitlement checks all contribute to finding oneself without a place to stay. The precipitating event may be eviction, by landlord, friends or family, but the underlying cause is destitution.

III. PROGRAM FEATURES

20. What geographic area serves as your agency's "catchment"?

	Total N=39 NA/DK=0	DSO N=12 NA/DK=0	DSV N=6 NA/DK=0	VO N=19 NA/DK=0	VP N=2 NA/DK=0
City Only	4(10%)	0(0%)	0(0%)	4(21%)	0(0%)
County	23(59%)	9(75%)	3(50%)	10(53%)	1(50%)
Multiple WI Counties	6(15%)	0(0%)	2(33%)	3(16%)	1(50%)
WI County & Border State County	2(5%)	1(8%)	0(0%)	1(5%)	0(0%)
Unlimited	4(10%)	2(17%)	1(17%)	1(5%)	0(0%)

Notes: Figures in this table are numbers of agencies.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

The majority of agencies focus on providing services to persons from their own counties.

21. List unduplicated count of persons receiving shelter in 1985 ______

Total N=37 NA/DK=2	DSO N=11 NA/DK=1	DSV N=5 NA/DK=1	VO N=19 NA/DK=0	VP N=2 NA/DK=0
17,763	6,353	8,515	2,584	311

Notes: Figures in this table are numbers of clients.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Some clarification is necessary when examining the above data. The unduplicated count of persons was probably higher than the figure cited above. A few of the agencies estimated their figures, because while they record the number of shelter nights, they did not always have unduplicated counts of individuals. They were asked to be as accurate as possible, underestimating rather than overestimating. Other constraints include the fact that one direct service only provider agency does not keep any records on those individuals who utilize the overflow facilities. Thus, the potential for the actual figure to be significantly higher must be considered.

The overflow capacity during the coldest winter months is considerable, at eighty persons per night. Additionally, some agencies compile data based on the number of families, not necessarily the number of individuals. These facilities were asked to multiply the average family size by the number of families to obtain a figure comparable to others. Several providers objected on the basis that this was 'deflating' their figures because many families are considerably larger than the average and family size in general is getting larger.

Two agencies were not operating during 1985 and are reflected in the NA/DK category. Some of the voucher only and voucher-prevention programs provide rental assistance, energy assistance and the like. The above figures however do not include these persons.

Thus, the figure of 17,763 is a very conservative figure.

In estimating the number of persons in need of emergency shelter it is necessary to also consider the numbers refused shelter and those who do not seek shelter or who do not know where to go for assistance in obtaining shelter. Estimates of this hidden population are hard to make because of the difficulty in verifying information. Some estimates that have been made use a ratio between the sheltered population and those unsheltered. Ratios range from 1 to about 1.5 for localities that have emergency shelter services. Thus the number of un-sheltered people in localities that have emergency shelter facilities can be estimated at between approximately 18,000 and 27,000.

22. Do you provide shelter without charge to the client?

	Total N=39 NA/DK=0	DSO N=12	DSV N=6	VO N=19	VP N=2
Yes	38	11	6	19	2
No	1	1	0	0	0

Notes: The figures in this table are numbers of agencies.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

All but one agency provides shelter without charge to clients.

23. Do you accept vouchers to pay for guest's shelter
If "Yes", which agencies provide shelter vouchers?

	Total N=39 NA/DK=0	DSO N=12	DSV N=6	VO N=19	VP N=2
Yes	5	3	1	1	0
No	34	9	5	18	2

Notes: The figures in this table are numbers of agencies.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

The majority of agencies (87 percent) do not accept vouchers to pay for guest's shelter. The few that did relied either on a particular Salvation Army, a particular Unified Services Board, or on the Dane County Social Services Department.

24. For each of the following services, please indicate whether your clients need the services, whether you provide or arrange for the service, and if you consider it a major unmet need.

Total: All providers (N=39)	Needed	Provide/Arrange	Major Unmet Need
Showers	22(9%)	37(11%)	3(3%)
Meals	22(9%)	37(11%)	3(3%)
Clothing	22(9%)	36(11%)	2(2%)
Housing Referral	22(9%)	32(10%)	22(19%)
Educational Services	17(7%)	17(5%)	12(11%)
Job Training/Counseling	20(8%)	22(7%)	21(18%)
Mental Health Services	20(8%)	26(8%)	16(14%)
Medical Services	20(8%)	19(6%)	10(9%)
Child Care	16(7%)	15(4%)	9(8%)
Info. on General Assistance	21(9%)	33(10%)	5(4%)
Advocacy	21(9%)	22(7%)	6(5%)
General (Info and Referral)	18(7%)	33(10%)	1(<1%)
Other	2(1%)	1(<1%)	4(4%)

Direct Service Providers Only (N=12)	Needed	Provide/Arrange	Major Unmet Need
Showers	12(9%)	12(11%)	0(0%)
Meals	12(9%)	12(11%)	1(3%)
Clothing	12(9%)	12(11%)	0(0%)
Housing Referral	12(9%)	12(11%)	5(13%)
Educational Services	11(8%)	6(6%)	3(8%)
Job Training/Counseling	12(9%)	8(7%)	7(19%)
Mental Health Services	12(9%)	7(6%)	8(22%)
Medical Services	12(9%)	7(6%)	5(13%)
Child Care	9(6%)	6(6%)	3(8%)
Info. on General Assistance	12(9%)	10(9%)	2(8%)
Advocacy	11(8%)	8(7%	1(3%)
General (Info and Referral)	10(7%)	9(8%)	0(0%)
Other	1(<1%)	0(0%)	2(8%)

Direct Service and Voucher Providers (N=6)	Needed	Provide/Arrange	Major Unmet Need
Showers	5(9%)	5(11%)	1(4%)
Meals	5(9%)	5(11%)	1(4%)
Clothing	5(9%)	4(9%)	0(0%)
Housing Referral	5(9%)	4(9%)	5(23%)
Educational Services	4(7%)	2(4%)	2(9%)
Job Training/Counseling	5(9%)	3(6%)	1(4%)
Mental Health Services	5(9%)	4(9%)	2(9%)
Medical Services	4(7%)	3(6%)	2(9%)
Child Care	4(7%)	2(4%)	2(9%)
Info. on General Assistance	5(9%)	5(11%)	2(9%)
Advocacy	5(9%)	4(9%)	3(14%)
General (Info and Referral)	5(9%)	5(11%)	1(5%)
Other	0(0%)	0(0%)	0(0%)

Voucher Providers Only (N=19)	Needed	Provide/Arrange	Major Unmet Need
Showers	16(9%)	18(12%)	1(2%)
Meals	16(9%)	18(12%)	1(2%)
Clothing	16(9%)	18(12%)	1(2%)
Housing Referral	16(9%)	14(9%)	10(22%)
Educational Services	14(8%)	8(5%)	6(13%)
Job Training/Counseling	14(8%)	9(6%)	11(24%)
Mental Health Services	14(8%)	13(8%)	6(13%)
Medical Services	15(8%)	9(6%)	3(7%)
Child Care	14(8%)	6(4%)	2(4%)
Info. on General Assistance	15(8%)	16(10%)	0(0%)
Advocacy	15(8%)	8(5%)	2(4%)
General (Info and Referral)	16(9%)	17(11%)	0(0%)
Other	1(<1%)	1(<1%)	2(4%)

Voucher and Prevention (N=2)	Needed	Provide/Arrange	Major Unmet Need
Showers	2(8%)	2(10%)	1(10%)
Meals	2(8%)	2(10%)	0(0%)
Clothing	2(8%)	2(10%)	1(10%)
Housing Referral	2(8%)	2(10%)	2(20%)
Educational Services	2(8%)	1(5%)	1(10%)
Job Training/Counseling	2(8%)	2(10%)	2(20%)
Mental Health Services	2(8%)	2(10%)	0(0%)
Medical Services	2(8%)	0(0%)	0(0%)
Child Care	2(8%)	1(5%)	2(20%)
Info. on General Assistance	2(8%)	2(10%)	1(10%)
Advocacy	2(8%)	2(10%)	0(0%)
General (Info and Referral)	2(8%)	2(10%)	0(0%)
Other	0(0%)	0(0%)	0(0%)

Note   The figures in this table are numbers of agencies.

25. a. Is there a limit on the length of time persons may stay in your shelter? If yes, how many nights?

	Total N=39	DSO N=12	DSV N=6	VO N=19	VP N=2
No (# of agencies)	9(23%)	6	0	2	1
Yes (# of agencies)	30(77%)	6	6	17	1

Shelters with limits	Total N=30	DSO N=6	DSV N=6	VO N=17	VP N=1
Ave. # nights	13	21	24	4	3
Range # nights	1 to no limit	7-180	3-90	1-15	3 to no limit
Is the time limit ever exceeded?					
Yes (# of agencies)	25(83%)	5	5	15	0
No (# of agencies)	5(17%)	1	1	2	1

Notes: Figures in this table are numbers of agencies.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Overall the average length of stay is 13 days. This figure is considerably higher for direct service providers; it is considerably lower for voucher providers. Most voucher programs are limited by the lack of funding and thus must curtail whatever activities they might wish to provide. Only one program reported a restriction in the number of nights they could provide services to a particular person or group of persons as mandated by governmental regulations.

Although the majority of agencies set limits on the number of days one can stay (77 percent), of those, 83 percent make exceptions usually based on an individual case need. Specific instances noted included those whose benefits or funds have been delayed; those waiting for permanent housing; large families; those who are sincerely making attempts to remedy their situations and others with needs as long as funds permit.

While some variation exists between the various types of service providers, the listed needs of those who are homeless were fairly uniform. Most agencies stated that generally they were able to match the needs. The major unmet needs cited were housing, job training/counseling, mental health services, and educations services.

26. Are there any conditions for staying in the shelter (e.g. refrain from smoking, leave part of the day, attend therapy, perform work etc)?

Almost all of the agencies reported conditions for involvement in their programs. Obviously the direct service providers had the most rules but there was a great variability between the programs. Voucher-type programs admitted that while they could not really enforce any restrictions, most request that their guests "be good" by not using alcohol or other drugs. Some did have income restrictions, social security number requirements and require general cooperation. Uncooperative or disruptive persons are usually denied future services.

Direct service providers consistently gave similar responses (though no one provider had all of these restrictions): no alcohol or drugs, no weapons or violence; restrictions on smoking; observance of curfew; be dressed; cleanliness; cooperation; evening prayer meetings; police-record check; or working on individually-tailored goals.

For all groups the most frequent request or requirement was to abstain from alcohol or drug use throughout the provision of services.

27. **What is the average length of stay for persons using your shelter?**

Persons in Families

	Total N=34	DSO N=7 NA/DK=5	DSV N=6	VO N=19	VP N=2
Length of Stay					
Mean	12.5	9	20	6	15
Median	10.7	8	18	2	15

Single Persons

	Total N=38	DSO N=11 NA/DK=1	DSV N=6	VO N=19	VP N=2
Length of Stay					
Mean	8.25	9	4	5	15
Median	5.87	4	3.5	1	15

Notes: Some providers supplied numerical estimates while others supplied percentage information. Conversions were made on the basis of the estimated total population served.

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

When examining the data for this question the median is the more accurate indicator of the average number of days because it adjusts for the few agencies whose policies, funds and abilities permits unusually long extended stays compared to other providers. It is evident that families stay for longer periods of time than single persons.

28. What is the average per diem cost to you to provide the shelter portion of your services (ie not including cost of meals or other services)?

	Total N=38 NA/DK=1	DSO N=11 NA/DK=1	DSV N=6	VO N=19	VP N=2
Average Cost	$15.84	$15.25	$14.01	$20.63	$13.50

Notes:		
	Total	All providers
	DSO	Direct Service Providers Only
	DS&V	Direct Service and Voucher Providers
	VO	Voucher Providers Only
	VP	Voucher and Prevention

Only three agencies needed to make an estimate for this answer. One agency had absolutely no idea of the level of their per diem shelter costs. Most agencies had the exact number right down to the penny. As the table shows there is considerable similarity, with voucher only programs being slightly more costly.

29. What proportion of your funding for homeless programs comes from each of these sources?

	Total	DSO	DSV	VO	VP N=2
Federal Government	6%	7%	12%	2%	5%
State Government	5%	10%	5%	3%	
County Government	6%	11%	9%	3%	
City/Town Government	3%	6%	8%	0%	
Fees Paid by Clients	3%	8%	3%	2%	
Churches or Private Charities	55%	45%	50%	61%	80%
Other Non-Government Sources	21%	13%	13%	29%	15%

Notes:		
	Total	All providers
	DSO	Direct Service Providers Only
	DS&V	Direct Service and Voucher Providers
	VO	Voucher Providers Only
	VP	Voucher and Prevention

30. Do you admit individuals with:

	Total N=39		DSO N=12		DSV N=6		VO N=19		VP N=2	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
mental health problems	38	1	12	0	6	0	18	1	2	0
history of alcohol use	39	0	12	0	6	0	19	0	2	0
history of drug use	38	1	12	0	6	0	18	1	2	0
physical disability (wheelchair, deaf blind)	37	2	11	1	6	0	18	1	2 2	0 0
developmental disability (eg mental retardation)	39	0	12	0	6	0	19	0	2	0
severe health problems	30	9	7	5	5	1	16	3	2	0
history of abusive behavior	32	7	11	1	3	3	16	3	2	0
current severe mental disturbance/ actively psychotic	7	32	2	9	3	3	2	18	0	2
current threatening or abusive behavior	1	38	0	12	0	6	1	18	0	2
who are intoxicated	3	36	2	10	0	6	1	18	0	2
who are under the influence of drugs	1	38	1	11	0	6	0	19	0	2

Notes:		
	Total	All providers
	DSO	Direct Service Providers Only
	DS&V	Direct Service and Voucher Providers
	VO	Voucher Providers Only
	VP	Voucher and Prevention

The persons most frequently not admitted are those who are under the influence of drugs or alcohol. Additionally, those who are currently displaying threatening or abusive behavior or who are currently experiencing severe mental disturbance/actively psychotic.

IV. UNMET NEED

31. On an average night during the past year, how many families and single persons (whom you would normally shelter) did you turn away for lack of space?

	Total	DSO Families N=4, NA/DK=0 Singles N=9, NA/DK=3	DSV N=6 NA/DK=0	VO N=19 NA/DK=0	VP N=2 NA/DK=0
Persons in Families	87 (36%)	20	4	63	0
Single Persons	156 (64%)	125	3	28	0

Notes: Figures in this table are numbers of people

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

These figures are quite inflated because they are skewed by one agency that reported an average of 110 turnaways under the DSO category for singles. The data is also skewed by one VO program that reported an average of 60 turnaways of persons in families. Both programs are located in the southern half of Wisconsin. The majority of agencies reported no turnaways on the average.

If turnaways vary by season.	DSO N=3 NA/DK=9	DSV N=1 NA/DK=5	VO N=5 NA/DK=14	VP N=0 NA=2
Total Average Low Season Turnaways	5 (2 Winter, 1 Summer)	2(Fall)	31 (3 Winter)	NA
Total Average High Season Turnaways	7 (2 Winters, 1 Summer)	5(Summer)	74 (2 Summer)	NA

Notes: Figures in this table are numbers of people

DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Perhaps the most interesting aspect of this question is the seasonal variation. In general the "low-season" includes the winter months, with the "high season" occurring in the summer months.

Highest number of turnaways at one time	DSO N=12	DSV N=6	VO N=19	VP N=2
Total	159	41	107	0
Range	0-100	0-35	0-75	0

Notes: Figures in this table are numbers of people

DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Again the reader is cautioned to remember that the high level at one DSO and with one VO agency skews the data. The ranges are provider in order to better clarify this data. An overwhelming number of agencies - 26 reported never having to turn away persons. Another 7 agencies reported turning away less than 10 persons at one time. Only a couple of providers qualified their low numbers by stating that referral sources might know they are filled and thus persons are turned away before ever reaching the doorstep of the provider. This phenomenon occurs in large cities (like Milwaukee) where a centralized refenring agency directs those in need to appropriate sources. This system also operates in smaller areas where frequently it is the police department that refers persons in need to providers. It was thus postulated that "if the police know we are filled or are out of funds they don't even bother to call us."

32. From your knowledge of your catchment area, what would you estimate to be the largest number of people in the area who are in need of shelter at any one time for whom no shelter is available?

	DSO N=8 Dk=4	DS&V N=5 DK=1	VO N=18 DK=1	VP N=2
Mean	82.5	11	23	25
Medium	19	13	4	25
Range	0-500	0-25	0-300	0-5

Notes:		
	Total	All providers
	DSO	Direct Service Providers Only
	DS&V	Direct Service and Voucher Providers
	VO	Voucher Providers Only
	VP	Voucher and Prevention

An examination by county will more clearly describe the unmet service needs as estimated by providers. In interpreting the following table it should be noted that not all counties or agencies are included. It may well be that other key informants would have different or additional estimates based on their particular viewpoint. For examples, police officers in counties with no emergency shelter provision (who would not be included in this survey) would no doubt be called upon to cope with people who become homeless in these counties. These officers would perhaps be able to expand the coverage of the information presented here.

Beloit County = 0
Brown County = 0
Dane County = 20
Douglas County = 5
Eau Claire County = 25
Fond du Lac County = 10
Kenosha County = 20
La Crosse County = 18
Manitowoc County = 0
Marathon County = 0

Marinette County = 0
Milwaukee County = 900
Outagamie County = 43
Racine County = 35
Sheboygan County = 22
Walworth County = 19
Washington County = 2
Waukesha County = 0
Winnebago County = 5

Total for counties covered = 1124

33. Where do those people sleep in the community?

The providers listed numerous places where people sleep. The most frequently occurring answer was: cars. Other frequently cited answers included buildings, lobbies, parks, tents, cardboard box, laundromats, everywhere, trash cans, on heat vents, bus depots, under bridges and in garages.

34. When they leave your shelter, what percentage of your clients:

	Total N=36	DSO N=11 NA/DK=1	DS&V N=6	VO N=17 NA/DK=2	VP N=2
a. go to another shelter	336(10%)	47(4%)	98(16%)	186(11%)	5(2.5%)
b. return to the street	467(13%)	103(9%)	32(5%)	330(20%)	2(1.0%)
c. return to housing arrangement from which they came	175(5%)	80(7%)	43(7%)	52(3%)	0(0%)
d. go to detox facility	56(2%)	31(3%)	18(3%)	7(<1%)	0(0%)
e. go to domestic abuse facility	48(1%)	8(1%)	21(4%)	14(<1%)	5(2.5%)
f. go to mental health facility (such as a hospital)	79(2%)	31(3%)	20(3%)	28(2%)	0(0%)
g. go to community mental health facility (e.g. group home)	45(1%)	10(1%)	25(4%)	10(<1%)	0(0%)
h. secure their own permanent housing	2078(60%)	693(64%)	308(51%)	982(58%))	95(92.5%)
i. other	205(6%)	87(8%)	35(6%)	80(5%)	3(1.5%)

Notes: Figures in this table are numbers and percentages of clients

Total	All providers
DSO	Direct Service Providers Only
DS&V	Direct Service and Voucher Providers
VO	Voucher Providers Only
VP	Voucher and Prevention

Due to staffing and funding constraints many agencies are unable to conduct follow-up activities on their clients. The figures above represent the best estimates providers could glean from their knowledge of their clientele. Sixty percent are thought to secure their own permanent housing. Thirteen percent are believed to return to the streets while another ten percent go to another shelter.

35. Are there other resource or services which need to be developed or expanded to help in addressing the needs of persons who are homeless in your area? What?

The answers to this question were quite varied and thus a summary listing of suggestions is presented by type of service provider. Multiple similar responses are designated by the number of asterisks preceding the statement. This compendium consists primarily of direct quotes as well as abbreviated content with the specific intent of showing not only the diverse thinking among providers but their language which in a large way reflects their attitudes about the people they serve.

Needed Resources or Services

Direct Service Providers Only (N=11, DK=1)

Region	Comment
1,1,2,2,3	*****Safe, affordable, low-income housing.
1,2	**Permanent housing for the mentally ill
1	Housing for chronic alcohol abusers
5	Low income housing for families not in abusive relationships
1	Low income housing for families
1	Single room occupancy hotels
2	Safe houses for psychotic homeless
2	SRO's for SSI recipients
2,2	**Less restrictive general relief policies that address an individual's immediate needs, not eligibility
5	We don't need flop houses
2	Job training and placement services
2	Health care for the uninsured
	A longer term shelter (1-4 months)
1	Jobs
1	More money
1	Start all over. We have to crack the cycle of poverty and not continue to contribute to dependency
2	Less restrictive shelter policies
1	Mental health services especially for alcohol and drug dependents
1	Stable funding
5	More Christian environments where shelters provide help by hitting at the core of problems: the lack of Jesus Christ in their lives
3	Landlords and owners willing to rent to families

Notes 1 = Milwaukee Region
2 = Dane County
3 = Eastern Region
4 = Southeastern Region
5 = Northern Region
6 = Western Region

Low income, safe, decent, housing is mentioned above and beyond all other recommendations. Alternative housing arrangements are suggested quite frequently, but with a variety of target groups mentioned.

Needed Resources or Services

Direct Service and Voucher Providers (N=6)

Region	Comment
4	Another shelter for families
4	Another shelter for single adult males
4	A shelter for single adult females
4	A shelter for single adult pregnant women of a transitional housing nature
3	Single room occupancy hotels, especially for men
2,4,3,4	****Low income permanent housing
	Case coordination
1,3	**Counseling - both crisis and on-going
	Street outreach
1	Health services
1	Meals
1	Clothing
1	Furniture
3	Waiver security deposits

Notes 1 = Milwaukee Region
2 = Dane County
3 = Eastern Region
4 = Southeastern Region
5 = Northern Region
6 = Western Region

Once again the most frequently mentioned need is that of low income permanent housing. Various shelters are proposed in addition to counseling-outreach and fulfillment of basic needs.

Needed Resources or Services

Voucher Providers Only (N=18, DK=1)

Region	Comment
1,5,3,3,3,4,4,4	********Low income, adequate, affordable housing
4	No more emergency housing
6,3	**More shelters
3,4	**More funds extended to existing shelters
6,3,3,4	****More money; tired of the band-aid put them in a hotel approach because this doesn't do much
5,4	**Housing for those on General Relief
4,3	**Centralized services, we're too fragmented
6	Desperate need of another shelter, especially for the "chronics" or "transients"
4	Funds for more standing policy rooms at hotels so there are beds available and at cheaper rates
1	Childcare so welfare mothers can find work or study
3,3	**Mental health care
3	More shelters and services
5	A community kitchen for those on food stamps
4	Coordinated case management to assist with getting people into entitlement programs
4	No, nothing needed
3	More money for gas to assist them to get to relatives or somewhere else where the grass is greener. Especially for large families because we just can't help them
3	Unskilled jobs
4	Money available to assist those facing eviction
4	Money for down payments and security deposits
3	Community support programs, especially for those who are mentally or physically handicapped without resources for medications and who often lack basic living skills
4	Alcohol and drug programs in schools aimed at prevention and early intervention least they become the homeless of the future

Notes 1 = Milwaukee Region
2 = Dane County
3 = Eastern Region
4 = Southeastern Region
5 = Northern Region
6 = Western Region

Once again low income housing leads the way with a large assortment of other suggested needs. These investigators found that the areas most in need are the larger metropolitan areas. Milwaukee, Madison, the Fox River Valley, and LaCrosse counties consistently reported an inability to meet the needs both effectively and appropriately.

Needed Resources or Services

Voucher and Prevention (N=2)

Region	Comment
5	Emergency lodging-another shelter
5	Jobs
5	Increases in the benefits of general relief
5	Repair substandard housing
4	Force landlords to provide energy efficient houses so that utility costs are contained
4	More FEMA money with relaxed laws that permit agencies to utilize the funds as needed
4	More money to keep families in their homes so they don't become homeless before we can help them
4	Advocacy with landlords
4	Secure, stable funding so we can better plan and allocate our resources with forethought rather than so haphazardly

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These programs suggest the repair and renovation of existing housing. They tend to utilize their funds by working with landlords to readjust payments, security deposits and the like. Rather than place someone in a hotel for a few days, they attempt to keep them in their present residence (if only for one more month) which allows for sufficient time to secure entitlement programs and is viewed as more cost effective.

36. Are there particular resources or services which need to be developed or expanded to help in addressing the needs of persons who are mentally ill and homeless in your area? What?

Needed Resources or Services For people with Mental Illness

Direct Service Providers Only (N=12)

Region	Comment
2	Permanent housing under professional supervision
1,2	**Expanded and continuous mental health care
3	Outreach to those who are choosing to be on the streets rather than wandering the streets scaring people
1,1,4,2	****General outreach
2	Medical services
6,4	**I'm not really qualified to answer that
	Rewrite the whole mental health laws
1	Medications are needed
1,1	**Supervision of medications
2	An SSI SRO
2	Safe Houses
2,4	**There are too few programs and follow-ups of those leaving state hospitals
5	God
2	Public housing for single adults
4	A shelter just to accommodate the mentally ill persons who are homeless
1,1	**More supervised group living
1	Monetary compensation for agencies that have "payeeships" which demand a lot of case management. time and follow-up
1	Decent, low cost apartment buildings with an on-site manager, but not a half-way house

Notes 1 = Milwaukee Region
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General outreach and case coordination is mentioned quite frequently. Housing is noted often but vast variation exists as to what form this housing should take. The regions most vocal are the Milwaukee and Madison areas.

Needed Resources or Services For people with Mental Illness

Direct Service and Voucher Providers (N=4, DK=2)

Region	Comment
4	Nothing special is needed
3	Need to help the chronic "street people" get help
1	Health services
1	Mobile meals
1	Cash grants for items not covered by food stamps, like pampers, tampax, etc.
1	Supervised housing
4	Outreach workers to arrange for housing
4	Affordable, clean housing

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A range of needs are mentioned from nothing, to housing, with assorted concurrent needs suggested as well. The reader will note the regional variation and even the intra-region discrepancies.

Needed Resources or Services For people with Mental Illness

Voucher Providers Only (N=18, DK=1)

Region	Comment
1	Decent housing
1	Community houses
3,3,4	***I don't know, I'm not qualified to answer
3,4,4,4,4	*****Nothing, there's no problem
4	More shelter funding
3	Affordable mental health services
3,4	**Basic needs - food, clothing, shelter
3	*Good housing just for the mentally ill
4,4,3	***Segregate them out from those who are just poor. Provide them their own special shelters
3	Community support program
3	Intervention to take care of medications, etc.
6	Outreach to get the revolvers and chronics off the streets
3	Centralized services
6	Get rid of the tramps, chronics and vagabonds, put them away. Of course, maybe they like it.

Notes 1 = Milwaukee Region
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The range of responses again varies tremendously, from "we have no mentally ill persons" to "get rid of the tramps, chronics and vagabonds by putting them away somewhere". The Walworth County consistently noted no problems with, and actually an absence of persons who are "mentally ill". Other cities within the same southeastern region however reported having extreme needs for this special population.

Needed Resources or Services For people with Mental Illness

Voucher and Prevention (N=2)

Region	Comment
3,5	***No special needs in this area

Notes 1 = Milwaukee Region
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A Note on 'Attitude'

In the course of this survey it became obvious how frequently some providers wanted to only work with the 'good' clients. The 'good' homeless client tends to be the young, adult, white, verbal, intelligent, sophisticated persons within the ranks of the homeless.

The most neglected people are those individuals experiencing high levels of emotional distress. In this situation it seems of questionable value to debate whether their emotional state is an expression of their homeless condition or if the "psychopathology" contributed to their present state of homelessness. A more telling barrier to securing help, which must be confronted directly, is that the humanistic advocates of moral treatment are, for the most part, not prepared to adapt treatment approaches to those surviving within the community. Many are reticent while others are totally resistant to working with individuals who differ so dramatically from themselves in socioeconomic status, education, and language.

Many members of our communities do not tolerate persons whose experience and current reality differs vastly from their own. People who are homeless encounter this intolerance on a daily basis, from the enforced early rising hours of some shelters to the studied indifference of the passersby on the street. It seems that the level of intolerance grows concomitantly with increasing visability and awareness of homelessness.

It is not at all surprising that people who work with the homeless will carry with them their own social attitudes. The low status of working with socially low statured persons may reinforce these social attitudes. The depth of the hostile attitudes of some providers toward there clients can perhaps be gaged by the fact that many are unaware that others might find their attitudes appalling. The reoccurring demeaning, degenerating labels affixed by these providers onto people with problems, converting and relegating them to being problem people, was quite casual. The clients were not people who happen to be homeless, but rather they were "homeless", as if that constitute an individual's entire identity. Providers apparently thought nothing of referring to an individual as a "tramp", a "revolver", "vagabond", a "chronic", a "street skut", "scuzzy", "filthy hobo", a "psycho", or "schizo" to name just a few. The data gathering techniques were not designed to elicit inappropriate terms, rather the providers in question seemed oblivious to the notion that anyone might find their attitudes offensive. It is difficult to believe that providers with such rigid values and beliefs could establish an understanding of these individual's daily realities.

By far, the majority of Wisconsin providers are genuinely warm, caring, empathetic, strong advocates for those who are currently clients and recipients. Luckily the majority of these providers lie within the larger communities and thus work with the majority of those who are homeless. This does not however, negate the reality that about one-third of the Wisconsin providers hold strong to such biased even prejudicial attitudes. We can only imagine that this 'attitude problem' might be even more widespread than uncovered due the social desirability of 'appropriate answers' inherent in investigations of this type.

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Papers on:

Policy Issues in Wisconsin

People who are Homeless in Wisconsin

Background Policy Issues in Developing A Wisconsin State Plan for People who are Homeless and Mentally Ill

A Coordinated Approach to Housing the Homeless Mentally Ill

Clare Stapleton Concord
Urban Information Consultants

Prepared for Division of Community Services
Department of Health and Social Services
State of Wisconsin

People who are Homeless in Wisconsin

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Homelessness in Perspective

During the European settlement of the U.S. temporary housing was common. However quite early in the settlement phase there was a recognition of the public responsibility for the housing or sustenance of the poor and the pauper. Early relief giving was based on traditional attitudes and policies derived from the English Poor Law system of relief. In this system a person was attached to a specific place [a Parish] and it was the responsibility of the parish to regulate the welfare of its indigent population. The eastern colonies and later the frontier states inherited the "local" pattern of relief and punishment for the indigent and vagrant classes. In Wisconsin the civil units of towns and counties substituted for the English parishes.

In Wisconsin, 1838 saw the first act for the provision of relief and support for the poor. This Territorial Act placed responsibility for relief with the county board commisssioners. As towns and counties were organized, provision for the destitute was seen as an essential element in local government. Almost without exception responsibility for relief was adopted within the first year; indeed many towns and counties had methods of relief prior to formal formation. In 1849 the new State of Wisconsin legislated for both county and town systems of relief. The mixed pattern of responsibility for relief has continued almost to the present time.

Historically, treatment of the indigent and dependent population in Wisconsin varied radically depending on public and administrative attitudes toward the cause(s) of an individual's dependence. As in many other states, the 'deserving' were given much better treatment than those perceived to have some degree of responsibility for their poverty or disability. By the 1860's there were several institutions established for segments of the dependent population (blind, deaf, insane, and delinquent boys). The indigent who did not fall into these categories (and some who did) were usually confined to local poorhouses. While the state institutions were generally overcrowded and under-staffed, appaling conditions existed in the local poorhouses. The county and town poorhouses were designed to discourage use. Located in isolated areas, their inhabitants faced poor food and lack of beds, sanitation, and even fresh water. In the words of the Board of Charities and Reform 1871 investigation conditions were 'filthy", "disgusting", "offensive", with "beds full of vermin", "walls clotted with blood", "urine running over the floor", and "a disgrace to the state".

The reform movement of the 1870's sought to improve the lot of those people already identified as 'deserving' as well as to extend the definition of 'deserving'. In 1878 and 1881, the "Wisconsin System" of county asylum care for the chronically mentally ill was introduced in an effort to relieve the overcrowding and mixing of people with mental illness, mental retardation, and the "chronic insane" at the state mental hospital, poorhouses, county jails and insane asylums. As a consequence 27 county asylums were constructed between 1880 and 1900.

Many mentally retarded people who were technically excluded from these facilities were classified as "insane" and committed to county asylums. However, as the cost increased the state (in 1894) responded by forcing counties to strictly enforce eligibility criteria, thus reducing state reimbursement. The net result was a surge of mentally retarded people who were admitted to poorhouses in the next three years. This example of progressive reform improving conditions for some, excluding some, and the subsequent adjustment by the service system has been repeated several times in the course of Wisconsin welfare history. In general, the aim of separating the deserving from the undeserving indigent has been conditioned by the cost of serving all those defined as deserving. The 'most deserving' were aided first and at the highest levels. Often 'most deserving' in the case of the indigent ment the quiet, clean, well behaved person who complied' with treatment and was not disruptive.

As the state began to serve segments of the population previously unserved or underserved, advocacy for expansion of those who would be eligible for services increased. Such advocacy embraced, for example, mentally retarded children, disabled aged, and people, particularly children, with multiple disabilities. While the State of Wisconsin moved into a more active position with regard to the dependent population the growing urban areas presented a new phenomena for Wisconsin: the emergence of urban concentrations of poverty. In the thirty years prior to the turn of the century, slums emerged in the larger towns and cities. By the 1890 Census it is possible to identify definite areas of the larger cities where concentrations of poverty and low quality housing coincide.

The Census primarily counted the domiciled population, but as the numbers of the poor increased, concentrations of homeless and near homeless individuals and families could be observed living in the open, in shanty towns, or in boarding houses. Relief agencies focused on these areas; their activities drew still more people who were homeless and discouraged competing activities. The outcomes of public policies which forced people who were homeless to leave specific locations included the establishment of relief agencies in areas of concentration of the poor and the focus on relief of current crisis needs (food, shelter), rather than long term solutions.

The Depression of the 1930s led to widespread poverty in Wisconsin, exposing the inherent structural problems of administering the Wisconsin system of relief. For the first time in Wisconsin, local units were directly aided by the state for the provision of public assistance. Moreover, for the first time the state treated local units differently according to the amount of need and the local unit's ability to meet that need. Federal funds for relief ended in 1936 and a reorganization of relief activities quickly followed. In general, counties became the focus of of relief (42 counties), while local units remained in control in 14 counties, and in 15 counites local units formed groups to administer relief. The mixed pattern of relief administration thus contiuned after the Great Depressionion and into the 1970s.

One legacy of the Great Depression for the welfare system was the Citizen's Committee on Public Welfare (1937). The Committee made many recomendations including the transfer of relief activities to the counties, the state funding of support for transients, and a work-based relief program for the unemployed. The recomendations of the Committee had little effect and the fragmented administrative structure continued. Again, there is a striking parallel with the reform era of the 1870s when a Statewide reform committtee made wideranging reform recomendations with little consequent reform.

The upturn in the economy during the Second World War reduced the destitution due to unemployment. The burden of relief was not entirely eliminated due to the number of people who were unable to work or were transient. There was little direct federal involvement in programs for the indigent in this period. The new Social Security system did not really grow substantially until after the end of the war so that most relief depended on local or state resources.

In the post war period pressures on the relief structure stemmed primarily from the growth in destitution due to unemployment. In the 1950's transient people were still vulnerable to arrest and vagrancy charges. The person with mental illness was also vulnerable to institutionalization which was seen as the most appropriate care for many types of mental illness. This is also the period of the introduction of major efforts directed toward the treatment of alcohol abuse as a disease rather than criminal offense. The change in attitude toward the abusive use of alcohol led to confinement in treatment facilities rather than jails. Thus several segments of the traditional homeless population were removed from the destitute group by being confined or moved on to another jurisdiction.

By the mid 1960's the elimination of substandard housing and skid row areas was seen as a viable public policy. The relative prosperity of the period had contributed to a decline in the number of people who were homeless and consequently the notion of urban renewal was seen as a practical method of dealing with the homelessness problem. It was thought that by removing the cubical and SRO hotels, people who were homeless would move to better accomodations (which in theory had been left vacant by households leaving the city). However, at the same time as skid row was being "renewed" other housing was being demolished or upgraded. Federal and city building standards required removal or renovation of substandard housing. In the 1960's these standards became progressively more stringent. The net result was a drastic reduction in availability of housing that was affordable for those in extreme poverty.

The upgrading of housing conditions and building codes were not limited to the large urban centers. Rural communities also enacted tighter building codes, often in response to state and federal aid programs. Rural areas in Wisconsin were faced with increasing expectations from their residents and increasing requirements from state and federally-mandated programs. While many rural areas lacked the financial ability to pay for these programs building and zoning requirements were 'cost free'; sometimes such programs brought additional funds and were thus of great appeal to rural local governments.

In the period between 1970 and 1980 Wisconsin there was marked growth in the homeless population. By the mid 1970's the number of people with mental disabilities who were homeless began to be of serious concern to shelter providers and mental health providers. In retrospect the increase in the number of people with mental illness who became homeless seems to have occured at the same time as the general problem of homelessness became more noticable. Yet this was not the only segment of the homeless population that experienced significant increases in the 1970s.

The restructuring of the economy coupled with severe recessions has produced high levels of unemployment. Most affected are those people least able to compete in the growth sectors of the economy. Thus as the demand for unskilled workers declines older unskilled workers become unemployed while younger unskilled workers can not enter the labor market.while younger unskilled workers can not enter the labor market. The net result in the late 1970s was a growing group of people who while willing and able to work could not find jobs in the labor market. With few resources these people became vulnerable to homelessness when their various entitlements (unemployment compensation, job training etc.) expire.

The late 1970's and early 1980's have seen the addition of more and more families to the homeless population. The rapid rise in rental rates, coupled with the virtual elimination of public housing construction has squeezed many families out of the housing market. In addition there is an increasing number of single parent households for whom securing adequate housing presents considerable difficulties. For many single parent households their income generating potential is too low to secure adequate housing. Thus even when working full time they are unable to support their family in an economy which is increasingly based on two income households. The families that become homeless place additional burdens on emergency housing services. Like the mentally ill person, families have special needs that traditional shelter providers have not been accustomed to meeting in the past.

Recent Increases in Homelessness in Wisconsin

The early 1980's saw the size of the homeless population of the U.S. increase dramatically. In 1983 it was variously estimated to be under 1 million (HUD) to as high as 2 million. In the last three years the national trend has been upwards, with the generally accepted figure standing at 2 to 2.5 million people per year. At the local level, the trend has also been upwards, but the rate of increase seems to depend on local conditions such as unemployment rates, and policies such as welfare and housing policies. While the absolute size of the population is a subject of considerable debate, there is a consensus that people who are homeless have significant problems. Approximately 40% of people who are homeless are heavy users or abusers of alcohol, 30% suffer from chronic mental illness, and virtually 100% are destitute.

In Wisconsin, the number of people who are homeless has been estimated at 22,000 (using the most conservative (HUD) approach) to 43,000 (using less conservative estimation methodologies). The precise number is not particularly relevent in the sense that the most conservative figure is cause of serious concern. In constructing programatic initiatives, estimates of the size of the homeless population is important for cost estimates: the need for some response, however, is demonstrated by even the most conservative estimate.

A survey of all known emergency shelter providers conducted as part of this research project yielded much information on the number and characteristics of people who are homeless in Wisconsin. The data, which was for 1985, indicates that on the average night in Wisconsin just over 500 people are sheltered through the agencies covered in the survey. On a yearly basis this represented a minimum of 17,763 individuals. Other research has indicated that for every person sheltered 1.3 to 1.5 individuals are not sheltered. Applying these ratios to the unduplicated count yields an estimate of the number of homeless in 1985 in the counties and communities covered in the survey of between 23,091 and 26,644. The figure for the whole state will of course be higher, but it is difficult to estimate how much higher since the omitted counties and communities are primarily rural and semi-rural and probably lack formal emergency shelter systems.

The homeless population of Wisconsin is very similar to the national homeless population and that of other midwestern states. Men and women are now more evenly represented than in the past, but this is largely due to the presence of large numbers of family groups (whose members were 63% female) since the homeless single population has remained predominantly male (71%) although this male predominance is declining rapidly; it was estimated in 1983 that males comprised 85% of the single homeless population. The population is much younger than even a decade ago, with families being a significant portion of those in shelters, but there are also larger numbers of young unemployed

Causes and Effects of Homelessness

a. Housing Markets

The growth of the number of people who were homeless that occurred in the 1970's surprised those who had predicted the demise of skid row and substandard housing in the 1960's. However, it is not so surprising if we consider the effects of a mix of Federal and State policies during the period. Urban renewal policies removed much of the lower end of the housing market in central cities, while stricter building standards raised the cost of housing in both rural and urban areas. For example, nearly half of the nation's SRO units were demolished or otherwise removed from the housing stock in the 1970s. The very poor resident could not afford or function in the remaining housing without a significant increase in social and economic supports. While economic and social support programs did increase, these program changes were not sufficent to ensure housing for many skid row residents. In the 1970s the total number of low income renter households fell from 13 to 9.2 million, but the number of available units also fell from 17.9 to 6.4 million (Low Income Housing Information Service).

In the 1980s low income housing has continued to decline. Federal subsidies for low income housing have fallen from $27 billion in fiscal 1980 to $10 billion in fiscal 1984. This is in a period when private housing construction was in a serious slump and few older units became available through filtering. In most major cities waiting list for public housing are being closed as the waiting periods grow longer. Smaller cities and towns have seen the elimination or reduction of housing programs. The increasing complexity of federal regulations has exacerbated problems caused by the shortage of funds. Local housing authorities are faced with the situation where there are homeless people and vacant public housing. A homeless family, for example, might be denied public housing because of the lack of a security deposit or furniture. In effect, they are too poor to secure what many believe to be housing at the bottom of the housing market.

While many housing units that might have sheltered people who are homeless have been removed from the housing market, others have become unavailable due to increasing cost or other barriers to access. It is widely believed that renovation and gentrification of downtown housing has made a significant number of people homeless by displaceing inner city residents. Apart from the removal of large numbers of SRO units, the data is to date not conclusive. However, the net effect of downtown revival, by raising the general level of downtown rents, has been to limit the number of housing units available to the very poor.

The problem of housing the homeless population extends beyond the number of available housing units to include the type of units available. Certainly the loss of SRO housing has been a major source males and females. Most people have no income: 45% of people in families and 58% of single individuals. Single individuals who do have some income are overwhelmingly on general assistance: families who have some income are prodominantly receiving AFDC, with some receiving general assistance.

Eviction by landlords, roommates and family disruption were the leading immediate causes of homelessness. However, the underlying cause was usually destitution. That is, the eviction was usually because of non-payment of rent. Since people become homeless because of destitution, and being unable to afford to travel they usually seek help in their own community. Three-quarters of the clients of the surveyed agencies came from the same county, and only 13% were identified as being from out-of-state. The proportion from out-of-state appears to vary with location and type of agency. Voucher programs such as those operated by the Salvation Army from United Way funds have a higher proportion of out-of-state clients than direct service providers, for example.

People who are homeless are often categorized as 'problem people' rather than people with problems. The information gathered in the course of this study indicates that the most pervasive problem is poverty. Families, in particular, are faced with poverty as their main presenting problem' (over 50%). Single people who are homeless also have poverty as their main problem (over 40%), but many also have the additional complexity of mental disability (20%) and/or substance abuse (26% - primarily alcohol).

It is the overlapping problems of people who are homeless that presents difficulties for emergency shelter service providers. For example, a person who is an abuser of alcohol, suffers from chronic mental illness, and has low job skills does not fit neatly into existing programs. Even the simple provision of shelter becomes a problem because rules which were normative in former years now present difficulties in the light of the changed needs of the homeless population.

The rapid growth in the numbers of people who are homeless further exacerbates the problem. Because there has been a lag in the allocation of funds to meet current needs, shelter and other service providers have been swamped with demands. Many agencies are devoting the majority of their budgets to emergency care, making little provision for long term projects which could bring the homeless in off the streets permanently.

of problems in large cities as well as in more rural areas. However, the population that is now homeless is somewhat different than that of the past. For example, more young people, more mentally disabled people and more large families are becoming homeless, indicating needs that the housing market is not meeting. Young people with very low or no income, but who do not live at home need inexpensive housing as they establish themselves in the labor and housing markets. People with mental disabilities may need structured and semi-structured accomodations that the housing market has not traditionally supplied and communities resist. Large families face increasing difficulties in finding affordable housing that will allow the family to remain together. All these groups may additionally face discrimination in the housing market. The discrimination may be based on their characteristics (age, mental disability or household size) or on the label 'homeless'.

b. Poverty, Unemployment and Destitution

Over the last decade there have been increases in unemployment in both the state and the nation. This unemployment would normally be transient in nature, but has become chronic in some localities and industries. Wisconsin saw a major loss of manufacturing jobs in the 1970's as employment growth focused on Sun Belt states. This ongoing restructuring of the manufacturing sector has been matched by continued restructuring of the rural sector. The rural crisis of low farm prices, excess production, and soaring costs has reduced farm employment to an all time low. Thus, Wisconsin is experiencing instability in two of its major employment sectors.

Unemployment does not necessarily imply destitution. Indeed, for most workers loss of a job may not imply any loss of income since a new job is often secured before the termination date. There are some workers, however, for whom loss of a job can have severe consequences. These are people who hold particular skilled jobs (such as automobile manufacture) for whom retraining will be necessary, older workers and people with few work skills.

In addition there are groups of individuals who face particular difficulties in the labor market because they have never been employed or have been out of the labor market for long periods; never employed young people, displaced homemakers, and released inmates of criminal justice or other stigmatizing institutions.

In sum, these groups constitue a whole range of people who are "second choice" for employers. These individuals face competition from better qualified or otherwise "first choice" individuals. In periods of prolonged unemployment this competition is particularly strong as the more desirable workers can take jobs below their skill level and hence crowd other workers out of their normal segment of the labor market. For instance, a person who is a day laborer may normally be able to pick up a few days work at a car wash, but with increased pressure for employment a college student may seek the car wash job, crowding out the person who would usually fill such casual positions. The net effect is to push the marginal worker out of the bottom of the labor market. Eventually these workers, become discouraged and are not counted in unemployment statistics. Because of the marginal job skills of these workers a period of unemployment can have devestating consequences since they are unlikely to have amassed significant assets to tied them over the period of unemployment.

In general, people who appear to have become homeless due to loss of employment tend to be marginal workers in terms of skills or work experience. These people have often been 'on the margin' for some time, so that re-employment involves over-comming a poor work history.

c. General Relief housing payments

Housing costs place severe pressures on the financial resources of many individuals. A person who is destitute often lacks the ability to purchase any housing and may turn to public resources such as general relief. General relief has been used throughout Wisconsin to varying degrees over time. In the last century these payments were called outdoor relief to distinguish them from indoor or almshouse or poorhouse payments. The idea of paying cash to the poor for food, clothing and shelter was generally thought to foster independence and to keep costs low.

Current administration of general (outdoor) relief usually includes payments for food, personal expenses, shelter, and often medical care. In theory the individual secures housing in the private market and the cost is subsidized or paid in full by the general relief program. Obviously, if the person already has housing there is no need for the payment. As the cost of housing climbs more and more general relief recipients are unable to find affordable housing. This is exacerbated by the need for security deposits. Without housing, the person can not obtain the general relief housing payment. Thus, a person who might be able to rent a room on a casual basis for part of the month is forced on to the street.

It is perhaps ironic that public relief which is the last strand of the social safety net can act to deprive a person of their ability to secure housing. To obtain general relief a person must lack resources. A person who is accumulating money toward a security deposit, however, may loose their general relief eligibility if they have any other assets.

d. Mental Illness, Deinstitutionalization, and Community Support Programs

Housing and income policies were not the only policies which contributed to the rise in the number of people who were homeless in the 1970's. The deinstitutionalization of people with mental illness which began in the mid-1960's reached its peak in the early 1970's. Some of the deinstitutionalized population became homeless and swelled the number of people on the streets. These individuals also fundamentally altered the characteristices of the homeless population. For most of U.S. history the homeless population contained relatively few people with mental illness, particularly when compared to the two major components: the economically disabled (the working poor and destitute) and the physically disabled (including the alcoholic). These two major components fluctuated in size with public attitudes and the state of the economy. Deinstitutionalization of people with mental illness thus added another major component to the homeless population, a component that service agencies were often completely inexperienced in dealing with in a community setting. Initially the chronically mentally ill person who become homeless had been deinstitutionalized and tended to be middle aged. More recently younger people who have been denied admission to mental hospitals have been added to the population. Thus, the mentally ill component of the homeless population has within it considerable variations in past experience and contact with the mental health system.

People with mental illness have long been a component of the homeless population. To the extent that they were seen as unintentionally ill, disabled and mentally ill persons have been viewed as deserving better treatment than the derilicts and bums of skid row. With the advent of deinstitutionalization in the mid-1960's people with mental illness were progressively released into the community where support services were to be provided. The hospital was to provide crisis care and ongoing care for those who were unable to live in the community. Involuntary admission was, in general, governed by the "immediate danger" standard which required that a person be an immediate danger to themselves or others. A large pool of vulnerable persons was thus created within communities unused to dealing with such persons. This pool grew further when persons who would formally have been admitted to hospitals were instead placed in community-based care systems. In terms of treatment, community based care has been recognized as an advance over previous methods. In terms of control, deinstitutionalized persons are certainly spatially and temporally freer in their behavior. In terms of quality of life, most analysts agree that there has been an improvement for the vast majority of mentally ill persons.

If community support fails, however, the usual assumption might be that the individual should be confined in an institution. However it seems that there are an increasing number of persons for whom life on the streets is the alternative. Concern over this outcome leads to a consideration of ways in which community support can fail. The failure with respect to people with mental illness who are homeless is complex in nature and has a variety of consequences. There are several sources of failure:

1. Deinstitutionalization: Were patients inappropriately discharged? Have we simply transfered the backwards to the streets?

2. Non-admission: Are new clients not being admitted to hospital care when their condition warrants admission?

3. Placement: Are clients being placed in vulnerable situations where they are likely to become homeless?

4. Support: Is there adequate community based support?

5. Re-admission: Are people kept out of hospitals in times of crisis? Has the revolving door closed with clients left out in the cold?

6. New-placement: Are there adequate mechanisms for resettling people who become homeless? Are the shelters sufficent to reintroduce a person back into a settled life style? Do the shelters act as portals to the society or as gatekeepers? (It is important to note that the shelter providers ofter see themselves as portals while the clients often see them as gatekeepers).

7. Service delivery: How responsive are existing modes of service delivery to the complex problems of people who are homeless? Are the institutional structures part of the problem rather than the solution? Do service agencies view persons who are homeless as individuals with problems or as problem individuals?

8. Housing policy: How has urban housing policy responded to the demands of mentally ill persons for inexpensive housing? While pursuing urban redevelopment have urban policy makers exacerbated the difficulties faced by persons who are homeless?

Each of the areas outlined tend to be intimately related because of the integrated nature of the health care system. However, it is important to note that it is the conjunction of conflicting policies rather than intentional individual actions that have allowed people to fall through the cracks." For instance, in the late 1960's did policy makers intentionally decide to urban renew downtown hotels or upgrade building codes so that newly deinstitutionalized persons would have nowhere to go? Obviously not, yet this removal of housing had a great impact on the available housing, and did contribute to the increasing number of persons with mental illness who are homeless.

e. Alcoholism and other drug abuse

Use and abuse of alcohol has long been associated with homelessness. In Wisconsin, shelter providers estimated that 12% of people in families and 26% of single people were substance abusers. The majority of the people seem by these providers were abusing alcohol. The role of alcohol abuse among the un-sheltered homeless population is thought to be much higher than the sheltered group (because intoxication is a leading cause of denial of shelter). Drug use and abuse is not as prevelent as alcohol abuse except for the younger age group.

A need for additional treatment beds seems to be indicated by the number of people who are homeless and substance abusers. However, it is not known how many people would seek or accept the type of treatment now offered. A large proportion of homeless alcohol abusers have already passed through several treatment programs. Consequently it may be that innovative programs rather than just new treatment beds may be required.

f. Physical Illness, Disability and Aging

People who are poor usually lack health insurance so that a major illness can severly delpete any savings. It has been estimated that up to half a million Wisconsin resident lack adequate health insurance. For these families and individuals the lack of insurance leads to inadequate care and the cumulative effects of untreated diseases. The effect is particularly severe when the person has health problems which impair employment possibilities. Lack of health care can then lead to lower earning capacity and lower standards of living.

Poor physical health usually does not in itself cause homelessness. It is yet another condition linked to poverty which can have compounding effects with the poverty of a family or individual. If the family or person becomes homeless their health condition is further threatened by the stresses and risks of life on the streets. Among the homeless population it is common to find high rates of malnutrition, TB, respiratory infections, hypothermia, hypertension, and digestive disorders. People who are homeless must also cope with lice infestations, leg ulcers, and trama related to day to day living on the street.

Provision of health care for the homeless population under the Johnson grant has begun in Milwaukee. The care is a major initiative in reaching people who are homeless. Extension of the Johnson grant to other communities is unlikely so those other Wisconsin communities will continue to have a homeless population with significant health needs.

Aging also plays a role in the process that leads to homelessness. Again it is not ageing itself but rather the correlates of low income and lack of employment that are more causally linked to homelessness. However, the aged person faces a particularly difficult time if they do become homeless. Because of their age and the felt or perceived vulnerability they are less able to compete for places in food lines or shelter queues. Some providers have recognised the added difficulties of the older person who is homeless by allowing an early seating at a food program for instance, or early admission to shelters.

g. Children: runaways and throwaways

Children who are homeless fall into three categories; accompanied by their parents, runaways, or throwaways (children forced from their homes). These categories are not absolutely distinct. For example, a child may runaway from home feeling pressure to leave and not be allowed to return.

Children who become homeless with their parents are seperated from their usual way of life, schooling is disrupted, and they are often confused and frightened. The few studies that exist show that parents attempt to secure as high a quality of food and care for their children as possible, yet these children also show higher rates of malnutrition and other physical and mental health problems than domiciled poor children.

Children who become homeless with their parents are undoubtly greatly distressed by the experience but do still enjoy the protection of their parent(s). Runaway or throwaway children are unprotected and are at higher risks of further abuse or exploitation. Shelter and voucher programs in Wisconsin do not accept unaccompanied minors, refering the children to runaway shelters or child protective service agencies. As with some adults, some children feel threatened by these agencies; that they will be forced to return home, that they will be institutionalized and so on. Unlike the situation of adults there are few options for the child who can not or who feels they can not return home. Most providers of low cost housing such as YMCAs or YWCAs will not take people under 18 years. Consequently 16 and 17 year olds who are essentially emancipated (through choice or through force) are left with few options. Their earning capacity is low because they usually lack adequate education so they are often unable to fully support themselves.

Summary

The increase in homelessness in Wisconsin has been extensively documented and is apparent in many communities. The causes of homelessness in Wisconsin are not substantially different than in most places in the U.S. While many communities have a long standing commitment to helping the poor and destitute the recent increase in homelessness has severly strained their ability to respond appropriately. Not only has the number increased but the addition of large numbers of families, people with mental illness, and young people has changed the service needs of the population.

The extent of the problem calls for concerted efforts on the part of all segments of the community. In many Wisconsin communities and other states, there is an emerging consensus that a public and private partnership will be needed to resolve the pressing issues of poverty and housing of the poor in Wisconsin.

Background Policy Issues in Developing A Wisconsin State Plan for People who are Homeless and Mentally Ill

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Background Policy Issues in Developing A Wisconsin State Plan for People who are Homeless and Mentally Ill

People who are homeless appear to be 'prime candidates' for service delivery agencies. They clearly have many of the difficulties (economic, physical, mental, behavioral), which are the traditional 'turf' of such agencies. Yet they appear to be ill served at the present time. This paper suggests some initiatives that may impact the ability of Wisconsin's social service agencies to respond to the needs of the homeless population. But before going on to that discussion, let us examine the question itself. How bad is the service provision for the homeless population?

On an absolute scale one can say that the level of services is very low considering the magnitude and complexity of the problems confronting the person who is homeless. Some individuals have such significant levels of need that to fully meet their economic, health and other needs would be very expensive. Many agencies simply do not have the capacity to meet those needs (or must trade off the needs of one client for another's).

Yet if we look at the present situation from a long historical perspective one would be tempted to conclude that services have greatly improved and in fact stand at an all time high in the U.S.

Even if the national leadership makes statements about some people being homeless by choice, that is a far cry from Benjamin Franklin stating that the poor should be allowed to starve (with no governmental intervention) as an example for others. So what we have is two perspectives; historically services to the homeless have improved but comparatively they are still well below that available to others in the society.

Historical Sources of Public Policy on Homelessness.

Historically the poor have been a very mixed group in terms of their paths to poverty, their living conditions and their needs. The working poor, the sudddenly poor, the vagrant, and the crippled beggar are all stereotypes to be found in the literature of most eras. Services to the poor reflect a recognition of these sub-groups and judgements as to their eligibility and worthiness for aid. Provision of shelter and support for the destitute has long been a matter of conflicting and at times incompatible aims. Feelings of charity toward the poor, the need for control, and the desire to reduce the number of dependent destitute people, have all competed in the formation of public policy. This conflict can be observed from the earliest period of colinization in the U.S. (and indeed in the source nations of the immigrants).

Just as there have long been destitute and homeless people there have been some segments that have presented difficulties for those concerned with providing longer term housing. The notions of the "hard to shelter" and "hard to serve" are perhaps as old as homelessness itself. Services have in the past gone first, and in many cases have been limited to, the easy to serve.

If we examine the early European almshouses it is apparent that there were very definite criteria applied to those seeking help. In the U.S. colonial period there were two sources of destitute individuals; domestic events (such as death, insanity or insolvency), and immigration. The colonial administrations employed various measures to control the influx of individuals likely to become dependent on the public purse. These measures included posting a bond prior to landing, requiring a guarantor for a job or for support, and outright refusal to permit landing. In effect these administrations sought to prevent new arrivals becoming eligible for public aid. Some colonies even required a residency of a year after landing before the person was considered a member of the community (and thus eligible for aid).

Residents were in a different situation because they, by definition, meet a basic criteria of eligibility, that of residency. Access to aid in colonial America was relatively easy for the deserving who were already part of the community. Even if the aid was minimal and not that which was desired by the individual there was little debate that some aid was a right. Widows and orphans were almost universally aided. The aged, infirm, and insane were in general viewed by governmental bodies and charitable organizations as entitled to aid.

The aid was not generous and was highly dependent on the 'warden of the poor', much depended on the prior standing of the individual in the community.

However, just as there were criteria for entitlement there were conditions for the actual provision of aid. As might be expected overseers were appointed to supervise the care of children and others judged incompentent. Other individuals were not usually as closely supervised but there were explicit or implicit standards of behavior. Failure to meet those standards of behavior were frequently cited as reasons for discontinuing aid (the most cited was drunkenness, but foul language, disruptive behavior, sexual behavior, and even "gossip" and "backbiting" are mentioned).

As the numbers of potentially destitute persons increased, particularly in the nineteenth century, various measures were taken to limit the burden on states and locatities. Measures included requiring complete exhaustion of personal resources and family support (extending to the degree of grandparents or grandchildren), increasing residency requirements, and compulsory work assignment. In addition behavior standards were more rigidly enforced to minimize both the cost of aid, in terms of money and effort, and to curtail the the numbers on the recipient rolls.

The most severe limitations were placed on the "able-bodied" and "non-resident" destitute. The former were not deserving while the latter were not entitled however deserving. A consequence of these views was that governments discovered that by changing the definitions of "able-bodied" or "non-resident" they could substantially impact the public dependency rolls almost instantaneously. For example, farm laborers were often unable to earn enough during the summer to support themselves over the winter. By changing residency requirements from three to twelve months itinerant farm workers could be denied winter relief (and forced to move on) because they could not accumulate sufficient money to stay long enough to become eligible for relief.

The effort to "move along" the itinerant worker in the U.S. is linked to the view of the needy population as containing distinct classes; the poor (through no or little personal fault), paupers (ie the long term destitute), and vagrants. The poor and a segment of the pauper group were viewed as being worth/easy to help. Temporary support, job training or other transitional aid was usually sufficient to lift the individual out of destitution- if not out of poverty. The "hard to serve", and hence the most likely to become homeless, in this period were largely drawn from those persons who were long term paupers or vagrants. These individuals were variously characterized as lazy, incorrigible, violent, drunk, shiftless and petty criminals. A major element in nineteenth policy toward the poor was the isolation and exclusion of these individuals. Exclusion from services was seen as encouraging a return to 'normal' work habits, but exclusion from the locality was also a priority since that would remove the 'bad example' that these individuals presented.

Debates over who was entitled to aid and to what kind of aid revolve around the three latent issues in policies toward the destitute namely charity, control and limitation or containment of the numbers of destitute. For some localities in the nineteenth century vagrancy as a status offence became a major mechanism for removal of the poor to work sites (eg workhouses, poorhouses, and farm camps). Yet even here there were standards for behavior; and again drunkenness and disruptive behavior were the prime reasons for dismissal (which would often mean jail).

While in the 1800's there was concern about the ability to control the feared unruly elements of the poor this was also the period of large scale reform movements (Dix, Addams etc). This is not such a paradox because the reform movements were largely directed toward helping the "worthy" poor. The "worthy" poor were those who with some assistance would "rise" and these were to be aided. The "others" showed little promise and reformers of the period advocated that they should be excluded from services (because they were judged to be undeserving). Because many of the reform movement were religiously based there was a consistent concern for the "moral improvement" of those recieving aid. It is perhaps even fair to say that there was widespread feeling that the lazy (ie vagrants) should be actively punished and made to work. Yet at the same time there are also many examples of workhouses and almshouses taking in vagrants (at least into the outbuildings) on particularly cold nights.

Modern Social Service Structures

Over the last 150 years as governmental and charitable organizations developed more extensive social programs, two changes occured that had the potential of decreasing the impact of destitution but also had the potential of increasing the problem of the hard core destitute. The first change has been the effects of reform movements in moving some groups of individuals from the undeserving able-bodied category to the deserving (sick) category by identification of an illness or other disability. Thus people with a mental illness, alcohol addiction or physical disability came to be regarded as deserving by definition. In effect efforts of containment of the deserving population had been relaxed which implied that there were more situations in which aid became a right rather than a matter of charity. With wider eligibility criteria and more recognition of "no-fault" destitution more people should become eligible for aid (there was of course the underlying funding limitation on the number of people actually aided).

The trend toward a wider definition of the deserving destitute was accompanied by and in part lead to the development of more specialized forms of services and programs. These more specialized regimes have at least the potential effect of allowing great control over the destitute by channelling people into specific programs. Refusal of "treatment" can lead to a cut-off in aid. Moreover the development of a ever more rigid set of channels has also caused the development of "cracks".

The mix of needs within the homeless population has emerged as one of the major difficulties in delivering services. The overlapping problems of people who are homeless presents difficulties for service providers. For example, a person who is an abuser of alcohol, suffers from chronic mental illness, and has low job skills does not fit neatly into existing programs. In the past the hard to serve person has tended to be the disruptive or "incorrigible vagrant" individual. The increased vulnerability to homelessness that these people experienced stemed from them being defined as ineligible. Presently there is a growing number of "eligible but not placeable" individuals.

The rapid growth in the numbers of homeless persons further exacerbates the problem because there has been a lag in the allocation of funds to meet current needs, so that shelter and other service providers have been swamped with demands. Many agencies are devoting the majority of their budgets to emergency care, unable to make provision for longer term projects. Individuals who fit neatly into existing programs can be moved out of the shelters but those who do not fit exactly may be literally "left out in the cold". It is not surprising that social service agencies are choosing the "best fit" candidates in a period of limited funds. Indeed when funds become very limited it would not be unusual for not only the "no fit" but the "partial fit" to be excluded from programs.

In sum then, the level of services to the homeless population seems historically to have three determining components. The first is the eligibility criteria used to determine those who can claim aid as a right. The second is the general level of funding for the relief of the poor. The third is the way in which the priority list is drawn up when the available funds are not sufficient to meet all the needs of the eligible group.

In the past funds have never been sufficient to aid all those eligible so that the poor have been ranked by service providers. Clearly the best chance of `success' are those poor who still have sufficient resources to maintain a dwelling so the homeless population as a class will tend to be ranked lower than the domiciled (indeed to obtain many services an address is necessary). People who are homeless thus experience a squeeze in resources when the needs of the domiciled poor increase.

Within the homeless population there is also a ranking. The best candidates for success being the first to be siphoned off into transitional housing programs etc. The residual group have been called the hard to shelter or the hard to serve and are a very mixed group of individuals. Historically, the major characteristics has been disruptive behavior (including drunkenness) and a perception that the person was an incorrigible vagrant (ie not willing to work). This historical view should be set against the very broad sweeping methods used in the past when dealing with the poor. All segments of the poor would be thrown together, particularly in the almshouses, with only minimal regard for individual characteristics or needs. The hard to shelter or the hard to serve person was one who disturbed the smooth working of these institutions or who returned again and again.

In the current era, the hard to shelter/serve group still contains disruptive and repeating individuals but also those who do not fit into the new institutional and programatic array that we have constructed. So many people are now homeless that the priority list has come to include, not only the disruptive and the chronic "repeater", but also those who encounter barriers to access to aid to which they are entitled. A major sub-group of these "no fit" or "partial fit" people are those individuals with mental illness (particularly if they also must cope with additional problems such as substance abuse).

It is as if the traditional almshouse of 100 years ago has been split up into specialist departments. In the modern period the specialist departments (sources of housing, physical health care, employment and training, food, and mental health services) are located all over the city. A person may be eligible to be in the almshouse but if the individual does not qualify for one of the departments, if the department is full, or if no department will take responsibility for the person they must wait in the lobby of the almshouse. The shelters of our urban areas and the vouchered rooms of the rural areas have become the lobbies of our now disaggregated almshouses. It is here that the destitute person is given shelter for a short period until, at least theoretically, they gain access to the appropriate source of help.

Likely Duration of the "Homeless Problem"

In constructing any approach to the problem of homelessness it is necessary to recognize that while an individual may not be homeless for the rest of their life (though some will), the problem may continue for the forseable future. The magnitude of the current problem and the resources that would be required to adequately address the accumulated needs of the homeless population (for shelter and other services) would absorb any budgetary allocation for a number of years.

Beyond the magnitude of the current problem, there is the consideration of the structural sources of the current problem. These structural problems will require a detailed reevaluation and restructuring of public policy toward the homeless population. For example, the profound disengagemnet of the federal government from housing and mental health issues has ramifications that are only now begining to emerge. Just as it took many decades to build up the federal role it will take some time to assess the consequences of its abandonment of its past role.

Public policy is usually thought of as including the goals and objectives which guide a goverment's actions. In the search for a policy on homelessness it will be critical to answer questions such as; Is there a public responsibility?, Who is eligible (what criteria are used and who decides)?, What aid is provided?, Who should provide the aid?, and finally, Who pays?.

A Coordinated approach to housing the homeless mentally ill

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An Coordinated approach to housing the homeless mentally ill

Homelessness is not a mental health issue, it is a housing issue.

While people who are mentally ill make up a significant portion of the homeless population in Wisconsin, housing must be seen as a precondition to effective delivery of mental health services. Just as effective therapy is best delivered after the patient is stabilized, so a person who is homeless is placed at a severe disadvantage in obtaining effective mental health care. Without the stability of secure housing, facing the danger and stress of life on the street, it is not surprising that a person with mental illness would have difficulty in taking advantage of mental health services.

Housing alternatives for the homeless mentally ill population has often been viewed as a dichotomy; the institution or the community. A person who did not 'make it' in the community would be regarded as a candidate for re-institutionalization. As with most false dichotomies this one draws on past and present practices without really looking at underlying concerns: why is community care seen as superior to institutional care, and why do some people have difficulty living in the community?

Community care is advocated as an issue of personal liberty, theraputic practice, and fiscal efficency. Institutional care on the other hand has been viewed as expensive, restricting basic freedoms, and of questionable theraputic value except in crisis situations. The failure of community placement is complex but often has at it's roots the poverty of the individual and an inability on the part of the housing provider, mental health care provider or the individual to deal with the particular living situation. In effect the 'community' as it is encountered by the individual may not be appropriate. This is a not uncommon experience in a society where people move, on average, every 3 years-- usually seeking an improved living environment. However in the case of a person with mental illness the normal residential dissatisfaction is often viewed as a failure in placement. Yet the need to change a person's placement in the community does not necessarily lead to homelessness. Other foctors seem necessary to precipitate an episode of homelessness.

In examing the characteristics of the homeless mentally ill population it is apparent that people who are homeless and mentally ill are usually very poor and/or are coping with other problems in addition to their mental illness. In some ways they resemble the 'problem patients' of the old institution models. In the past the 'better' (more cooperative, better behaved) individual received higher levels of care in the institution, while less cooperative, less well behaved individuals were more likely to be heavily druged and confined to the 'back wards'. Now that people with mental illness are in the community it is not surprising that the 'better' behaved person are also better served. The challenge is perhaps not how to better serve the homeless mentally ill population but how to begin serving them.

One begining is the provision of accessible emergency shelter. Another is the provision of affordable, appropriate housing. Another is the provision of mental health services. Other beginings are employment training and placement, physical health care, and ongoing social and economic support when necessary.

None of these activities are new, rather what is called for is the articulation of existing federal, state, and local policy initiatives in all of these spheres of public policy. In several of these areas there has been considerable change in levels of support and locus of responsibility in the last few years. As the federal government has moved out of both mental health and housing policy formation and support, responsibility (and the cost of services) has devolved to the states and localities. With this shifting of responsibility there is both the opportunity for the development of flexible locally based initiatives, and the problem of significant increases in demands on local and state government. Homelessness is but one problem which calls for the attention of the public and policy makers. Thus redirection, coordination, and improvement of existing programs seems to offer the best course of action.

A Three Phase Approach

There has been much discussion as to the 'best' method of dealing with the homelessness problem. State initiatives have varied from punitative efforts, aimed at getting rid of the homeless via zoning and other ordinances coupled with removal of services (including pressuring private charities such as the Salvation Army to close), to comprehensive efforts which aim at both immediate assistance and long run solutions. Recognizing the Wisconsin tradition of innovation in the area of social services and the strength of some segments of its mental health system leads to the expectation that the state of Wisconsin will likely develop a strategy on homelessness that builds on these strengths.

In considering how such a policy should be crafted political and fiscal constraints as well as the existing social service sector must be recognized. A policy strategy which disrupts existing programs as little as possible, yet, potentially, focuses considerable resources on the immediate and long run problems of the homeless population can be summarized as a three teired or three phased approach. First, emergency shelter for those people now on the street. Second, facilities and/or services for stabilization and transition (and for prevention for those people vulnerable to homelessness). Third, permanent housing, employment and support where appropriate.

In the first teir physical safety is the immediate concern. In this emergency phase shelter, food, clothing, rest, and financial assistance ready the person who is homeless to begin a sustained effort at reintegration. The difficulty of this first phase can not be underestimated. There are many paths that lead to living on the street and re-entry must often be tailored to a person's individual needs rather than the programatic needs of the shelter or agency.

The second teir of this approach involves mobilizing services to facilitate an individual's or family's transition toward more permanent housing. These services could include, physical and mental health services, social support, and employment assistance, in addition to continued housing assistance. It is in this phase that the person who is homeless will have to deal with the complexities of the array of programs available in Wisconsin. Many person who are homeless have in the past experienced difficulties in with these programs and agencies. Thus there is a need for strong supportive individual advocacy in this critical period.

The third teir or phase involves placement in or assistance in securing, long term housing, employment if appropriate, and the organization of continuing support if required. The success of this phase depends on the availability of permanent housing and on the prevention of the re-emergence of the conditions that led to the person becoming homeless. For example, securing of employment where income is too low to pay the rent will almost certainly lead to eviction and another episode of homelessness without some continuing economic support.

This three phased or three teired approach has evolved in several countries and U.S. states. It recognizes that the problems of the person who is homeless are immediate and can not be defered until long term solutions are worked out. In other words, there is little to recomend a policy that allows people to freeze while permanent housing is constructed. Likewise a policy that only provides emergency shelter (and traps people in the lowest teir) is equally unacceptable.

Current Wisconsin Programs

How does the present array of programs and services in Wisconsin compare with this model? Are there changes that would improve the effectiveness of existing programs with regard with the homeless population? As previously noted most of the services that would form the building blocks of a three teired approach to the problem of homelessness already exist in Wisconsin.

Of particular interest here is the person who is mentally ill and homeless. When examined from the point of view of the person who is both mentally ill and homeless access to array of services is constricted by the rules, practices, and eligibility requirements of most services.

In the first teir most shelters and voucher programs in the state do not serve with severe current mental disturbance (such as being psychotic). Agencies that directly shelter the homeless population serve a higher percentage of people who are mentally ill than other types of agencies. But almost all agencies deny access to their, services if the person appears to be in crisis or actively disruptive. This is a very difficult situation for the provider, particularly when a referal to a mental health facility will not likely lead to a commital. The provider is then faced with the options of refusing service or attempting to deal with an individual who may be very disruptive to other clients, staff, or referal providers (eg to motel operators in the case of voucher programs)

> Recommendation State and local mental health agencies should work with each program providing shelter. directly or indirectly, to the homeless population to articulate a 'secure referal' process. Such a process would provide a shelter-of-last-resort for people that the program would not serve because of apparent mental illness but who are not clear candidates for committal procedures. The existance of the shelter-of-last-resort should be made known 'on the street' and to referal agencies (including such groups as churches and the police). Funding for such shelter provision should be a priority in the States budget initiatives. This might include a 75/25 ratio of matching for those agencies who would serve as a shelter-of-last-resort.

To the person who is homeless access may present a considerable barrier. The rules, practices, and eligibility requirements of most shelters and programs are well known 'on the street'. A person may not seek shelter knowing that they will be denied or because the burden of the shelter bureaucracy. Many individuals voice the fear that if they use a shelter or other program when they are in crisis they will be institutionalized. Again the person will 'choose' to remain on the street for fear of the consequences of seeking shelter. It must also be acknowledged that people who are homeless are often afraid of the violence, degredation and vulnerability to victimization that they feel, particularly in shelters. These (too often valid) fears lead to 'choice' of the street as a safer place than the shelter.

Vigorous street-based outreach, 'zero level shelters', and 'warm rooms' all attempt to provide highly accessible, minimal structure services. Although part of the first teir such services are by their nature, very difficult to formalize within current social service models. Not only are the modes of operation unorthodox, often involving extensive 'bending' of the rules, long periods spent in establishing contact with a potential client, and intensive case management where contact is established, but there is often little change in terms of life style or apparent quality of life. Moreover the people and agencies most skilled at this type of work may not necessarily be public agencies or the trained personnel usually sought for social work positions. For example, the average "burn-out" period for street workers in New York City is six months for social workers but up to a year for volunteers-- a critial difference when attempting to re-engage a person who is homeless. It is also true that church based and volunteer-run programs have much higher 'street acceptance' than public shelter programs. Thus use of the normal accountability, quality, and outcome measures is of questionable use in evaluating such programs.

> Recommendation Development of public policy toward the homeless population should recognize the diversity of the population in terms of backgrounds, problems, needs and capacities for change. Policies should avoid broad classifications of people since one major reason that people are homeless is that they did not fit into existing programatic classifications.

> Recommendation Any initiative in the area of homelessness should recognize that the homeless population is difficult to reach and shelter at least in part because of their past experience with public agencies. Effective actions will likely come from locally based groups or agencies, many of whom will be private in nature, and who have built up strong linkages with people in need in their communities. The structure of these groups which make them particularly successful with the homeless

(flexible, informal, accepting of lack of change) may not make program administration particularly easy. It should be the goal of funding sources to adapt to meet the needs of such groups. While public accountability should be preserved, unnecessary and unduly complex regulations should be waived so that the funds can support such innovative programs.

Recommendation Specialized facilities that serve particular segments of the homeless population should be supported when such facilities might ease the barriers to the homeless person. For example, separate facilities for women in Milwaukee and Madison seem justified, because in both cities there is concern for those women who are afraid to use existing facilities.

In the second teir the initial task is to mobilize resources to assure shelter and income. Once a person is assured a minimal level of housing and income security it becomes possible to address other areas of need which may be preventing the person securing permanent housing. Many of the services that might be required at this stage are well established. For example, in most larger communities in Wisconsin, mental health and social services, employment training and placement, and housing services are all available. The problem for many people who are attempting to stabilize their living situation is one of access. The need for identification (such as birth certificates, permanent address), and in some cases financial resources (for security deposits, commuting costs etc) may effecively exclude a person who is homeless from existing services. In other cases the lack of coordination between existing agencies may undermine the effective functioning of the system. For example, securing housing beyond a reasonable commuting distance to a community mental health care center may not be effective since it may lead to the person withdrawing from treatment.

The missing link for many people who experience recuring homelessness is sustained case management. A person who is homeless could have several case managers, a shelter worker, a general relief worker, and a housing counselor, but if a problem occurs it may well be the responsibility of the person in crisis to coordinate all these worker's plans. This coordination will be in addition to securing food and shelter as well as any other needs such as health care or employment training. Public and private programs often lack the resources necessary to offer this kind of sustained assistance in negotiating the complexities of 'the system'.

> Recommendation The state and localities should examine existing programs and assure that people who are homeless are served (even if that means modifying current program requirements). The state could provide strong leadership in this area by mandating and enforcing the requirement that all state funded programs serve the homeless population, and that all programs recognize shelters as valid addresses for administrative purposes. Such a mandated approach has worked well in other states (Mass. for example) and would have an immediate impact.
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> Recommendation The State should anticipate passage of a federal Homeless Persons Act by examining federal "pass through" programs to identify those programs whose local implementation also may inadvertantly exclude people who are or have recently been homeless.
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> Recommendation All agencies involved in discharging clients should review their practices to assure that discharge does not lead to homelessness. There is a special need to plan for young people leaving foster homes and other placements. These young people may lack the job skills and training necessary to secure adequate incomes.
>
> Recommendation Sustained coordinated case management should be encouraged between agencies. Shelter and transitional residence workers are best placed to have sustained daily contact with the person who is homeless, so other agencies should be encouraged to place workers directly in shelters or transitional residences. For instance, there should be a mental health care

worker in each major shelter or transitional residence, who would serve the clients in that shelter or transitional residence This service may be as an advocate with other agencies, a coordinator of daily activities or simply as a source of continuity. To a person with a history of fragmented, inconsistent, and sometimes conflicting even rejecting treatment such a contact may effect more stabilization than any other single activity.

A major gap in Wisconsin services available to people who are homeless is assured transitional housing. Shelters now serve both as emergency shelter and transitional housing. Individuals must compete for shelter each night so that the person is in a constant state of anxiety as to their nightly shelter. Voucher programs usually only pay for 1 to 3 nights accomodation so again the person has no sense of stability. Many states and localities have found that separate facilities (such as duplexes, small houses, existing YMCAs and YWCAs, and independent apartments) can serve as assured temporary housing for the period when a person is getting their situation in order. Such facilities can be the locus of stability and continuing support. For example, a person may need assistance negotiating the public housing authority requirements or in securing employment. By staffing such residences with personnel skilled as housing and employment counselors the person who is attempting to leave homelessness is provided with both the security of assured housing and people who are immediately available to assist in the next steps to more permanent housing. As with emergency shelter provided in the first teir the goal of the second teir is to move a person on more secure living situations.

Recommendation Localities should set aside some housing units to be used for transitional housing. A program using duplexes already exists in Milwaukee. Expansion of the number of emergency (tier 1) beds available should be critically examined in the light of the need for more secure (teir 2) housing. Agencies may be reluctant to reallocate resources to such facilities (for example, should the housing counsellor come from the emergency shelter budget or the housing authority budget?). The state may be able to play a leadership role without significant outlay of funds by establishing a demonstration program that would fund counsellor positions in transitional housing facilities and serve as an inducement to set up this type of program.

Recommendation Special attention should be paid to the transitional housing of people with particular needs. For instance, there is a need transitional housing for people with severe mental illness. Many individuals who are not acceptable to shelter providers are nonetheless in need of housing. Transitional housing for these people may take the form of small housing units, rather like group homes, but with the intention of providing a transition between the street and more permanent housing. People may spend up to a year or more in such 'minimal structure/maximum focus' residences.

The third phase in the process of leaving homelessness can be thought of as involving increasing stability in many areas of a person's life. Adequate stable income sources must be established (either via employment, entitlement programs or a mixture of sources), access to adequate physical and mental health care (as appropriate) is also necessary, social support must also be organized if required. In effect the third teir of this approach aims at assisting the individual to secure permanent housing and the means to hold on to that housing. There is a critical difference between placement of a person who is homeless in housing, and organizing a network of resources that will allow the person to stay in that housing on a long term basis.

The availability in Wisconsin of a range of housing, employment and support services provides a firm foundation for assembling a 'resource package' tailored to meet the needs of individuals. A young AFDC mother may need training (with quality day care) and employment and supportive social services. An older person may require physical health care and adult day care. A person with mental illness may need conection with a community mental health program and a semi-structured living environment (such as a YMCA or YWCA) but no other special services.

Because of the range of needs of people who are homeless and the existence of programs that meet most of these needs (albeit on a piecemeal basis) separating the homeless population as a special target group would only serve to further stigmatize individuals and would not necessarily lead to increased resources. Rather than looking to the people as the problem, programs can be examined to determining why they are failing people who are homeless. For example, training programs that do not include child care, employment situations that do not allow absences for necessary physical or mental therapy, or housing that does not provide access to desired activities (such as employment, social and recreational opportunities) may not serve the needs of very low income people.

Within the array of resources needed by people who are homeless, housing is critical. Providers of services list housing as the major unmet need as do advocates for people who are homeless. The 198

State Housing Plan has as a goal to

> Provide decent quality housing at affordable cost, located and designed to meet the needs of households whose incomes are so low they cannot participate effectively in the housing market without assistance, and for households with other special housing needs.

Considering the needs of people who are homeless a variety of housing options are desirable. The continum of housing services could range from non-structured facilities such as private apartments, duplexes or houses, to more structured living situations such as SROs, YWCAs and YMCAs, group homes, and boarding homes. In recognizing the diversity of the homeless population it is not surprising that their housing needs will be as diverse as those of the general community. The major difference is the inability of people who are homeless to compete in the housing market because of their low incomes.

The need for the preservation and even construction of SRO types of accomodation is a good example of the difficulty in securing housing at the lower end of the housing market. Although the need is widely recognized the private market is not producing this type of accomodation due to the lack of profitability of SROs since they must meet minimal safety and maintaince regulations. Public providers of housing loans may also be reluctant to finance such developments because most of their residents will have no income at all.

Yet if the State of Wisconsin is to fulfill the promise of the State Housing Plan innovative solutions must be found. Low Income Housing Task Forces are currently studying the situation in Milwaukee and Madison. With the findings of these studies available detailed plans can be formed for those cities. Faced with the same types of problems in developing long term housing other state and localities have developed a series of initiatives. Massachusetts has earmarked a significant amount of new unit construction for large families, The City of New York has developed partnership arrangements with private charities, usually churches, to run SROs, and many communities have developed public/private real estate partnerships for the construction and/or operation of very low or no-income housing.

> Recommendation The State of Wisconsin should make a commitment to the development of housing for all its residents. Development of this housing will require a partnertship between existing governmental bodies, corporations, foundations, housing authorities, advocacy groups and private charities. The State should take a leadership role in bringing together these actors in addressing the needs of very low income people.
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> Recommendation The State should study the appropriate structure of public/private programs to assist private voluntary organisations in providing housing for people with special needs. These organizations often lack the capacity and capital resources to initiate housing programs. Facilitating voluntary organizations can be a way of promoting housing for vulnerable people without significant involment of public monies.
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> Recommendation WHEDA is in a unique position to provide leadership, expertise, and financing for the development of low income housing. Its policies and procedures should be reviewed to determine the extent to which WHEDA can participate in the development of SRO and other innovative projects. Production of this type of housing should have priority in the WHEDA adgenda.
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> Recommendation Innovative housing demonstration projects should be supported by the State. The long lead time, cost and developmental difficulty involved in testing new and innovative housing solutions calls for housing initiatives to be tested and

the results distributed in the most efficient manner. The State is in a position to assist in the development of such programs by providing linkage to other programs, by providing some financial assistance, bv evaluation studies, and by wide desemination of the results.

Recommendation Existing housing programs may inadvertantly exclude people who are or have recently been homeless. A review of their rules is necessary. The State can play a leadership roll in such a review by mandating it for its own programs but also by the development of guidelines for the use of smaller govermental units who may lack the resources to develop their own review procedures.

Recommendation Existing programs which assist low income individuals to remain in the present housing should be encouraged. Early intervention is perhaps the least expensive and least disruptive course of action. Two programs now exist and the sate and localities should be encouraged to sperad them further.

While the critical need is for housing other factors should not be ignored. Unless housing is provided on a free basis, stable sources of income are necessary to prevent homelessness. As previously noted the third teir involves the securing of housing and the means of holding on to that housing. That may mean income support for members of the working poor particularly single heads of households. It may mean increasing general assistance housing payments so that they cover the cost of housing. Finding ways to increase income levels of the very poor may also include training and re-training (which may require some changes to employment training programs).

Construction of An Integrated Approach in Wisconsin

The building blocks for a concerted effort on behalf of the homeless population of Wisconsin are already available or could be made available relatively quickly. The major problem in the development of such an effort will be the effective leadership required to bring together the braod range of actors who shape the reality of people who are homeless. Because so many of the programs that affect the person who is homeless are either mandated, funded or regulated by the State, any plan must have heavy State involvement. The State is also the only body capable of mobilizing the human and financial resources that will be required.

The State is not the only actor. Indeed much of the expertise in dealing with the problem of homelessness is to be found in the voluntary organizations and public agencies who provide shelter and services for people who are homeless. Foundations, churches and private individuals who support the work of the agencies are also major actors. So are advocates for people who are homeless, associations supporting people with mental illness or alcoholism, and low income advocacy groups. A long run solution will also require the involvement of the housing industry and employers. These actors will be critical in the development of adequate affordable housing and the primary means of holding on to that housing, employment.

State involvement will not solve the homeless problem in Wisconsin but without State involvement the problem will not be solved. The State is in the position to bring together the diverse actors, experts, advocates and the victims of homelessness. With strong leadership at the highest levels coordination between governmental departments and cooperation between the public, private, and charitable sectors can be effective in focusing resources on the problem of homelessness. In Wisconsin where the level of social services is relatively high the need for massive amounts of financial resources is unlikely. Nonetheless some additional funds will be required. These funds can come from redirection of programs that are not yet serving the homeless population, or from new funds raised by the public or private sectors.

Conclusion

Growing recognition that people who are mentally ill may be particularly vulnerable to becoming homeless has led to a range of initiatives at local, state, and national levels. Just as there is no simple answer to how the problem developed there is no simple solution. Thus there is quite a range of approaches to identifying both the dimensions of homelessness and ways of dealing with the problem. Initial studies aimed at getting accurate counts of the number of people on the street, and providing sufficient shelter space. While this remains an ongoing concern, many agencies and research studies are now turning to considerations of longer term solutions. In many communities the immediate crisis has been met, at least in part, so that there is now the possibility of planning for more than emergency shelter.

Long run solutions to the problem of homelessness will be neither simple nor inexpensive. Service delivery to vulnerable individuals as well as those already on the street is likely to involve rethinking of delivery models. There is a need to re-examine models, particularly with respect to the multiple problems that persons who are homeless often have to deal with on a daily basis. While some agencies are already deeply involved in service delivery to people who are vulnerable or actually homeless, a wider involvement will probably be necessary for long term solutions to be successful. Agencies and groups not normally associated with persons great distress will likely be crucial because their actions can have profound effects. A decision to convert an apartment house to condominimums, to demolish an abandoned building, to change a building code, or to change security deposit policies can have direct implications for people on the margins of the housing market. While service agencies may be very aware of the impact of even slight changes in eligibility rules there is a much broader group of actors that have a the problem will thus necessarily rest on the development of consensus among service agencies, and a range of public and private individuals and groups.